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Bulletin of
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EDITORIAL NOTE

This is the first of a projected series of issues of the *Bulletin* which will appear from time to time devoted to consideration of the relations of psychiatry to other medical and surgical specialties. These relations, embracing the complex etiological, resultant and concomitant roles which psychological or emotional factors play in all types of human illness, comprise the most recent emphasis in medicine, sometimes being referred to as psychosomatic medicine.

The thesis of psychosomatic medicine can be simply stated: The individual is a psychological-chemical-physical unit, and not, as he is so often regarded by the strict organicist in medicine, a personality owning and operating a body which, like his automobile, may get out of order. Everything that happens to this individual-as-a-unit has psychological, chemical and physical aspects, but medical tradition is so rooted in anatomy, chemistry and physiology that psychology is often viewed as irrelevant and unscientific. Psychiatrists are partly to blame for the still meager acceptance by other physicians of their research findings, clinical observations and theories regarding psychological and emotional factors in disease because their writings include so much special terminology "jargon" that physicians in other specialties cannot understand them.

We as psychiatrists and neurologists have not had extensive experience in this field. What experience we have had has been with "nervous" patients with physical symptoms or illnesses who themselves suspected an emotional basis for their suffering, or whose physicians were far-seeing enough, after ruling out organic disease, to refer them for psychiatric investigation and treatment instead of simply dismissing them. This experience has, therefore, been of a clinical, rather than of a research nature (although several research projects in psychosomatic medicine are now in progress at this Clinic) and has been supplemented by a continuous survey of the increasing amount of literature in this field.

The Editors of the *Bulletin* felt that they might render a service to physicians in non-psychiatric specialties by presenting in readable form the contributions from the literature and from the writers' own experience which psychiatry has to make regarding the role of emotional and psychological factors in the conditions dealt with in the various specialties. In an

endeavor to promote ccoperation and "respectful attention" between each of the specialties and psychiatry, the Editors plan to include in each of these special issues of the *Bulletin* an article by a prominent medical or surgical specialist in the field to which that issue is devoted.

We have begun with a consideration of the specialty of gynecology and obstetrics, a field in which there already exists, perhaps beyond that in other specialties, an awareness of the importance of etiological, concomitant and resultant psychological factors, since the sexual-reproductive processes are obviously physiological *and* chemical *and* psychological. Special issues devoted to other medical and surgical specialties will follow at irregular intervals.

This issue of the Bulletin is being sent to a number of physicians not among our regular subscribers by means of a fund contributed to the Menninger Foundation by Mrs. Albert Lasker of New York who is especially interested in the possibilities of a wider utilization of psychiatry in other medical specialties and in general medical practice.

THE EDITORS.

GYNECOLOGY AND PSYCHIATRY

By Robert Latou Dickinson, M.D., F.A.C.S.*

The psychological aspects of the practice of gynecology and obstetrics have interested me for many years and I have a strong conviction as to the need for coordination of research and for the exchange of views between specialties. Hence I was glad to comply with the request of the Editors of the *Bulletin of the Menninger Clinic* to write some introductory remarks from the standpoint of the gynecologist for their special issue of the *Bulletin* dealing with the contributions psychiatry has to make to the understanding of certain gynecological problems.

Happily one does not have merely to theorize about or plead for such coordination, for one may cite outstanding examples of it dating back several decades. In 1907, Professor Pfannenstiel of Jena had one of his gynecological staff (Ernst Grafenberg) spend an hour a day in the psychiatric clinic. Grafenberg examined 300 female patients admitted to the university hospital for mental diseases in Kiel in an attempt to confirm or disprove the claims of Bossi, well-known Italian gynecologist and university professor in Genoa, that mental illnesses were caused by gynecological lesions and could be cured by proper treatment of the pelvic pathology. Grafenberg's findings were that female mental patients had only the usual percentage of gynecological diseases, and that the mental illness was essentially unaffected by cure of the gynecological condition. Siemerling, director of the mental hospital in which Grafenberg made his examinations, then carried on a sharp debate in the literature with Bossi, the outcome being that Bossi's ideas fell into oblivion. Siemerling's remarks in one of these papers ("Gynecology and Psychiatry," published in 1914) are very pertinent to the present series of papers in this *Bulletin*. He wrote, "It is not gynecology which has taken up an abode in mental institutions, but instead, psychiatry which has come into its own in gynecology and general medicine."

In this country the most noteworthy all-round attack on marriage problems began twenty years ago at Mount Sinai Hospital in New York when Max Mayer, trained in both specialties, integrated gynecology and psy-

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chiatry. He found that one-third of some 500 new patients per month in the women's clinic had some problem of marital mental hygiene, of child adjustment or of conception control. At the Margaret Sanger Research Bureau in New York, Dr. Robert W. Laidlaw of Columbia has worked particularly with husbands. In dignified quarters and with much privacy, the Cincinnati Committee on Maternal Health and the Cleveland Health Center have attacked the psychic maladjustments with as much care as the physical. Ernest Groves at Chapel Hill, Raymond Squier and Mary Fisher at Vassar, Dearborn in Boston, Bessie Moses and Adolf Meyer's service at Johns Hopkins, Mrs. Mudd in Philadelphia, Valeria Parker in New York—all are examples of the progress in coordination and conjoined study of the individual. The National Committee on Maternal Health underwrites research in the fields where psychiatry and gynecology overlap. Perhaps better beginnings have been made in coordinating these two specialties than in any other combination which seeks to deal with psychosomatic problems.

The best solution of such problems may be reached in an institution which is well-manned (and "well-womanned") where provision is made for adequate time and teamwork. Meanwhile, as a practical method of promoting progress, the two specialties can cross-fertilize. The psychiatrist can teach the gynecologist to study the patient's emotional attitudes and predisposition in terms of upbringing, unfavorable experiences, and present emotional situation; he can point out the need for time to talk and the importance of several appointments—preferably placed at the end of regular office hours—to permit investigation of emotional factors in the presenting complaints. On the other hand, the gynecologist can suggest to the psychiatrist that if he would take a refresher touch course he could examine his patient as soon as he has her confidence and might thus effectively short-circuit a long diagnostic search. I believe that confidences are much easier toward one person than toward two or more. Follow-up is simpler; authority is undivided. Group study is advantageous for medical and surgical conditions, but not for marital-emotional troubles. I also believe that psychiatrists can master the common pelvic diagnoses better than obstetricians and gynecologists can delve into neuroses and psychoses.

Aside from the question of scientific progress in the field of mind-body problems—progress which is earnestly desired by leaders in all the specialties—the public is demanding help in these problems which lie in the overlapping field belonging to both gynecology and psyhciatry. Books on marriage and problems of sexual adjustment and child rearing have mounting sales. Birth control clinics, whether located in public health centers, hospitals or as extramural agencies, find themselves besieged with demands for help on problems other than physical ones. These they cannot under-

take to handle, except in a very few places, because of the time requirement for psychological investigation and re-education and treatment. The discovery of structural disease factors is relatively simple and three patients can be seen in one hour. But even one hour with one patient is but a beginning in eliciting emotional conflicts, fears and frustrations and more hours are essential to bring each patient to some solution. Talking takes time, but talking, when it is done with a trained psychiatrist, or with a gynecologist oriented and interested in psychiatry, has powerful therapeutic values.

The new frankness of approach of the younger people, the new demand for reciprocal satisfaction, the freedom of women in their ability to elect self-support, all these bring new demands upon us of the two specialties. The multiplying of the self-confident, ill-trained individuals who offer marriage advice also gives us reason for collaboration. The psychology of infertility, voluntary or involuntary, is as important as that of excessive multiparity. The balk at pregnancy, the determination to interrupt with unwarranted conditions, and the aftermaths thereto are matters for our joint counsel, at meetings such as the recent weighty conference on abortion, at which A. A. Brill spoke courageously. The really new development in psycho-somatry of sex concerns the neglected male. Fertility dependent on the efficacy of immensely valuable four-footed sires has been subjected to intensive study but similar interest in the non-hairy primate has only occurred lately in the elaborate researches I started under the National Committee on Maternal Health. Urology will join our group and take on premarital examination and sterility investigations.

It is to be hoped that such unions between specialties as is exemplified in this special issue of the *Bulletin of the Menninger Clinic* will help all physicians in their recognizing and managing those human ailments and complaints which would, without knowledge of psychiatric contributions, be, like Lady Macbeth's illness, "beyond their practice."

FUNCTIONAL DISTURBANCES OF MENSTRUATION

MERTON M. GILL, M.D.

The physician, dealing as he does with the phenomenon of menstruation in every working day, may sometimes come to regard it as a commonplace, banal human experience. But to non-medical persons—both men and women—menstruation is a subject surrounded by pain, mystery, anxiety and even guilt and fear to an extent far beyond one's first thought. The taboos under which the menstruating woman lived in primitive society attest to the malevolent influence that she is considered capable of exercising. Even to this day, she is supposed in some rural communities to sour milk, cause mares to abort, blight crops, etc. Mary Chadwick in her monograph *The Psychological Effects of Menstruation* presents an interesting and illuminating parallelism between the conception of the menstruating woman among primitive peoples and the influence attributed in the seventeenth and eighteenth centuries to witches.[1] Outstanding is the conception that the menstruating woman is dangerous. The taboos have, as their general purpose, the protection of the male from the menstruating woman, lest she rob him of his masculinity. This threat of the menstruating woman to man's virility leads us into a discussion of some of the principal psychological reasons that the recurring menstruation awakens such a profound disturbance in many women. This paper is an effort to present our knowledge of the psychology of menstruation in its relation to the functional menstrual disorders.

A. THE PSYCHOLOGICAL MEANINGS OF MENSTRUATION

The position and meaning of menstruation in the physiological sex cycle are well defined. Menstruation has its psychological aspects, too, and psychologists and psychoanalysts now understand the broad outlines of the meaning and significance of menstruation in the psychic economy. Unfortunately unification of the understanding of these two aspects in the clinical management of the woman with a menstrual disturbance is for the most part incomplete. This defect becomes of especial importance in the treatment of a woman with a "functional" menstrual disorder, because in such instances the psychological significance of menstruation to the woman may play the prominent etiological role.

Menstruation is a badge of femininity. The widespread rejection of femininity and the envy of the male among the women of our culture is a phenomenon too well known to require documentation. The bloody menstrual flow is, in the unconscious mind of many girls, taken as proof of their deficiency and inferiority. It frequently becomes associated with adoles-

cent masturbation so that the guilt and anxiety which accompany masturbation become related to menstruation as well. The shame and secrecy with which society surrounds the subject of menstruation lend credence to the girl's belief that the menstrual flow is a punishment she suffers because of her "sins." Menstruation can therefore act as a powerful stimulus to feelings of aggression and resentment against the male. The girl's feelings of inferiority, discomfort, inability to partake in her usual activities in contrast to her male contemporaries is attributed to the function of menstruation which she therefore regards with resentment. These feelings of hostility—usually conscious only in their superficial implications—arouse great guilt and fear of retaliation and the effort to deny them and to project them onto men is responsible for much of the bitterness with which many women accuse men of degrading and belittling them. The unconscious recognition of the hostility of the menstruating woman is partially responsible for the taboos by which primitive men seek to protect their masculinity from her malevolent influence. An important role in the construction of these taboos is also played by the psychological conflicts of the male, but this will not be discussed here.

The lay person's thinking about menstruation revolves mainly around the subject of childbearing. Most women, even though they be entirely ignorant of the physiological processes involved, correctly regard menstruation as a necessary accompaniment of the ability to bear children. The manner in which the individual woman is oriented to the problem of childbearing is of basic importance in evaluating her personality structure. Psychological conflicts which have their genesis in the early interpersonal relationships of the little girl's family life, may lead her as a woman to view childbearing with guilt, anxiety and resentment. The normal woman's wish for a child is unencumbered by these disturbances. She sees the child as something given to her by her husband in love. The woman who in the main rejects her femininity views the child with scorn, dread and even abhorrence and is insatiable in her demands for "equality" with the male. Most women fall somewhere between these two groups and have contradictory feelings about childbirth. It is something which they desire but not without conflicting impulses laden with guilt, anxiety and fear.

The psychological significance to women of menstruation can thus be viewed from the standpoint of their orientation to childbearing. In the woman who desires a child without guilt, but for one reason or another has none, the period may produce the depression of disappointment. Menstruation has been called "the weeping of the disappointed uterus." The woman who rejects childbearing may be anxious premenstrually and then relieved when the onset of the menses proclaims that she is not pregnant, though her relief will be mixed with resentment that this recurring

mark of femininity awakens in her. Mixed feelings assail the majority of women who may therefore suffer from contradictory symptoms expressing their opposing wishes. Thus in a subject recently studied in hypnosis with Dr. Margaret Brenman, the patient vomited premenstrually as an expression of rejection of the wish to have a child and suffered with cramps which to her were a psychological equivalent of labor. When she menstruated she felt a mixture of depression and relief—depression because she had not born a child and relief because the anxiety and guilt over the wish to bear the child were removed.

Another important meaning of menstruation to women follows from the fact that the menstruating woman is regarded as "unclean," since menstruation thus acquires the psychological constellations relating to excretion and cleanliness. The woman has no voluntary sphincter by which to control the time and place of the menstrual flow and may feel the same guilt and anxiety that was in childhood associated with accidents in sphincter training. The excessive fear that so many women have lest they offend by the odor of the menses can be related to the equation between the menstrual function and excretion.

A number of authors stress the factors of "imitation" and "expectation" in the woman who is "sick" at the time of her period. Either some female relative suffers from the same menstrual discomforts that the patient shows or else she has been reared to regard herself as in a highly precarious and delicate state while menstruating, so that she must cease many of her normal activities, avoid getting chilled, or getting her feet wet, etc. Indeed menstruation is a "sickness" to the vast majority of women and it is hardly surprising that they conduct themselves as "unwell." An interesting paper by Louise Brush[2] lists many colloquialisms by which menstruation is known, the vast majority of them referring to being hurt or sick.

B. DYSMENORRHEA

It goes without saying that the investigation of a case of menstrual disturbance must be initiated by a thorough gynecological examination. It can be too easily assumed, however, that some minor physical deviation from normal is the cause of the disturbance. The example that springs to mind is the often suggested association of dysmenorrhea with uterine displacements. The overwhelming mass of evidence now indicates that there is no relation between the two and that minor displacements are without clinical significance[3]. The frequently reported good results in the treatment of dysmenorrhea by the correction of uterine displacements must be explained as the result of suggestion.

It is dangerous to assume that the success of a form of therapy is proof of a theory of etiology. Some believe for example, that the relief of dys-

menorrhea by presacral neurectomy proves the cause of dysmenorrhea to lie in disease of the presacral nerve. One could with equal justice say that the relief of the intractable pain of a carcinoma by rhizotomy proves that the cause of the carcinoma is to be found in the posterior nerve roots.

Dysmenorrhea is of course the most common and important of the menstrual disturbances not clearly grounded in organic changes. We are here concerned with the "essential" or "idiopathic" dysmenorrhea in which organic factors have been ruled out. The nature of dysmenorrhea is veiled in mystery. As yet there has not even been any clear-cut demonstration of the relation between uterine contractions and dysmenorrhea[4].

To say that the cause of dysmenorrhea may be psychological is not to deny that in dysmenorrhea a disturbance of physiological function exists and will be found. A psychological cause can act on the body only through the medium of physiological change. For example, a correlation between dysmenorrhea and excess of one of the sex hormones in the blood still requires explanation in terms of the cause of the excess hormone. The immediate cause is presumably change of function of an endocrine gland but the basic cause can *a priori* as likely be "emotional" as organic.

Theories of dysmenorrhea are many and contradictory and have succeeded one another in tune with the prevailing gynecological interests of the day. The theory of stenosis has been abandoned, though it was once so tenaciously maintained that even swelling of the mucosa about the internal cervical os was regarded as a possible etiological factor in dysmenorrhea. The fact that most instances of essential dysmenorrhea are discovered, on careful questioning, to have begun sometime after the onset of menses effectively demolishes the theory of stenosis[5]. Displacement of the uterus has been held accountable not only for dysmenorrhea but for countless other female ills, but is now conceded to be of insignificant import. The present fashion is to account for dysmenorrhea on endocrinological grounds. Unabashed, side by side, stand the theories of too much estrone, too little estrone, too much progesterone, too little progesterone. Each investigator reports some measure of success with therapy based on his theory. The subsequent followups reveal many recurrences. This sequence of contradictory theories, therapeutic success by *opposing* techniques and subsequent recurrences is one which we are beginning to recognize bespeaks the psychosomatic disease, or at least the disease in which psychological factors play an outstanding role. An example in point is that of peptic ulcer. It will be recalled that peptic ulcer has been variously cured by alkalies, histidine hydrochloride, and the urine of pregnant women.

The relief of dysmenorrhea which sometimes follows on marriage and the establishment of a regular sex life, and in other instances after the birth of

a child, is sometimes regarded as substantiating a theory of dysmenorrhea on the basis of an infantile uterus or some other organic deficiency which is corrected by the vascular or hormonal changes associated with the establishment of the regular sex life or the birth of the child. But many instances of dysmenorrhea set in only *after* marriage or childbirth. It is clear that it may be the psychological repercussions of marriage and childbirth on the pre-existing conflicts which result in either the appearance or amelioration of the dysmenorrhea.

There are in the literature a number of reports of remarkable results in psychological investigation of and psychotherapeutic approach to dysmenorrhea. Novak and Harnik for example, report that 247 cases of dysmenorrhea revealed, in each instance, psychic traumata[5]. The majority of the traumata lay in the sexual sphere but the authors report that many appeared unrelated to sexuality. In most of these latter cases the patients feared that some injury had been caused by their carrying on during menstruation some activity that they had been warned against. It may well be of course, that a deeper study of these cases would reveal the relationship to sexual material or rather to the type of conflict outlined in the first part of this paper. With the use of psychotherapy, principally directed to a recovery of the memory of the trauma followed by reassurance, Novak and Harnik report therapeutic success in 132 cases, relief in 67, failure in 11, and inadequate followup in 37. The traumata found by Novak and Harnik show no specificity in their relationship to the dysmenorrhea. To the psychiatrist their case reports are rather surprising in that excellent results follow on very superficial exploration and therapy. Wittkower and Wilson studied 57 unselected patients with primary dysmenorrhea and found their personalities to fall into two main groups—"the first characterized by deep resentment of their feminine role; the second obviously immature physically, and either shy and shut in or chronically anxious and complaintive."[6] Similar findings are reported by R. Allers[7].

W. Dick reports a number of instances of rapid and remarkable cure in dysmenorrhea through the use of hypnosis[8]. Successful hypnotic control of menstrual disturbances has been also achieved by Dr. Margaret Brenman of the Menninger Clinic in a number of cases soon to be reported. W. Dick also reports on the apparent interchangeability of the dysmenorrhea itself with pains elsewhere in the body and with mood disturbances and specifically mentions headache, abdominal pains, migraine, weakness, backache and depression. To these should be added the nausea and vomiting that so often accompany the menses. He found instances in which the hypnotic suggestion that dysmenorrhea would cease was followed by the appearance of one or more of the other manifestations which he calls

"dysmenorrheal equivalents." This substitution of a new symptom for an old one suggested away in hypnosis is an infallible criterion of the psychodynamically grounded symptom.

C. OTHER MENSTRUAL DISTURBANCES

A common accompaniment of the menstrual cycle which may be designated as one of the functional disturbances of menstruation is "premenstrual tension." Many women are pre-menstrually tense, anxious, tearful, irritable and generally out of sorts. Ordinarily this state is explained by the explicit or implicit correlation of the disturbance with physiological changes—the psychological disturbances being regarded as concomitant to the "stress of bodily adjustment." The frequent presence of pre-menstrual tension without any disturbance of the physiological menstrual cycle lends support to the probability that the genesis of the state is to be found in psychodynamic factors. It will be clear from the preceding discussion of the psychological significance of menstruation that the symptoms of anxiety and irritability may be the result of any one of a number of different psychic conflicts which are activated by the anticipated menstrual flow. Karen Horney finds the initial impulse to the pre-menstrual reactivation of these conflicts in a pre-menstrual heightening of heterosexual desire[9]. She found that such tension states occur even in a woman psychologically normal but unable to gratify her wish for a child and/or normal sex activity as a result of external conditions.

The work of Benedek and Rubenstein offers a considerable illumination of the details of pre-menstrual psychodynamics[10]. They have carried out studies correlating ovarian activity with psychodynamic processes (through dreams and psychoanalytic material) and find regular relationships between estrone and progesterone levels and active heterosexual trends and passive receptive tendencies, respectively, in the successive phases of the menstrual cycle. The work is of great importance and requires amplification and checking by other investigators on both the physiologic and psychodynamic levels.

Menstruation appears to be astonishingly susceptible to psychological influences and it is perhaps this easy influenceability of the process which accounts at once for the frequency of menstrual disturbances and the ease with which menstruation is influenced by hypnosis and by superficial psychological exploration. Heyer reports that he has in many instances been able in a single hypnotic session to successfully suggest delay of the menstrual flow in actresses and singers[11]. If he chooses a time not too far removed from the expected menstruation he can suggest the exact time of onset of the flow. Paneth reports the turning of the three weeks cycle (no

other complaints) into a four weeks cycle with a single hypnotic suggestion, the change having persisted at the time of reporting for 2½ years[12].

Complete cessation of menstruation due to psychological factors is most strikingly seen in "false pregnancy." This condition also demonstrates clearly how the presence of endocrine changes does not rule out the possibility of an underlying psychogenic etiology since false pregnancy is accompanied by typical pigmentation, swelling of the breasts, etc., which must take place by the medium of endocrine changes. There are numerous cases of psychogenic amenorrhea scattered throughout the psychiatric literature (cf. e.g. M. J. Eisler.[18]).

The curious delayed menstruation in the woman who fears pregnancy is well known to every gynecologist. One suspects that behind the conscious fear of pregnancy lies the more basic wish to bear a child. The occasional onset of the delayed flow in the physician's office directly after the woman has been told that her fears are groundless again attests to the striking influence of psychological factors. Equally well known is the premature onset of a menstrual period when pregnancy is feared, a phenomenon which seems more in line with the conscious psychological factors. In the literature one finds frequent references to the influence of any strong affective experience on the menstrual cycle. Even a normal flow in an usually normally menstruating woman may suddenly be interrupted by a temporary emotional disturbance. What we need of course for a scientific understanding of these problems is accurate and detailed investigation by collaborating gynecologist and psychiatrist.

Another well known phenomenon in point here is that of the psychologically determined premature onset of menstruation classically seen in brides, but sometimes also in women who have unconscious aversion to intercourse and use this method to avoid it. (See Karl Menninger[13].) Balint[14] also discusses this phenomenon and stresses the opposing wishes that the unexpected menstruation signifies; namely, the desire to excite and seduce the man, but at the same time to frustrate and disappoint him. Menninger comments that it remains for future investigators to determine whether these uterine bleedings correspond to a true menstrual flow. One may suspect that in all probability the flow is comparable to that of an anovulatory cycle.

Instances of prolonged uterine bleeding with almost continuous hemorrhage in which the etiological factors were psychological have been described by several authors. Novak and Harnik[15] saw a number of such cases, and report three of them in detail. Although again many types of psychic traumata appear in the various cases, the wish to avoid sexual intercourse is the dominating theme. Most of these patients had been treated unsuccessfully for months or even years, and most of them were

cured by psychotherapy of a superficial sort. Miller reports several such cases under the title of "Psychogenic Menorrhagia"—though from his description the cases again are those of metrorrhagia, rather than menorrhagia[16]. Novak and Harnik also report cases of menorrhagia in the strict sense, following psychic traumata[15]. The menses continued with the usual regularity but the period itself became more profuse and prolonged.

D. GYNECOLOGIST AND PSYCHIATRIST

The psychiatrist does not ordinarily study instances of menstrual disturbances as such. Only when they occur in the setting of a psychiatric problem do they become his province and even then they figure generally only in the background, so that his knowledge of them is incidental.

It is the gynecologist who sees the vast majority of the functional menstrual disturbances and in most cases he can and should act as his own psychiatrist[17]. In particular the experiences of Novak and Harnik indicate that through relatively brief and superficial psychotherapy, far-reaching therapeutic benefits can be obtained. While it is true that psychotherapy is a rather time-consuming procedure, the chronic, refractory and disabling character of so many functional menstrual disturbances, especially dysmenorrhea, make this expenditure of time well worth while.

Much more work in cooperation between the psychiatrist and the gynecologist is necessary before we will be able to thoroughly elucidate the problem of specificity between emotional conflict and menstrual disturbance, but for practical clinical purposes much can be accomplished for the patient by sympathetic discussion and reassurance.

The gynecologist must study the woman suffering from a functional menstrual disturbance not only organically but psychologically as well. A relatively brief discussion of the patient's attitudes and beliefs regarding menstruation may quickly reveal erroneous conceptions which can be corrected or psychological traumata which sympathetic discussion and reassurance may rob of much of their pathogenic influence.

Much can also be done by the gynecologist in the use of prophylaxis against the functional menstrual disorders. Education of women as to the error of certain primitive superstitions and beliefs regarding menstruation and frank discussion of the problems involved will do away with much of the mystery and fear with which the function is surrounded. It may be that far-reaching effects cannot be obtained until a generation of women who have been instructed by their gynecologists will have reared their own daughters, but the reward would be well worth the effort.

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THE EMOTIONAL FACTORS IN PREGNANCY

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In the broad field of medicine, each specialist group tends to isolate itself from other groups of specialists. When a man in one field records opinions regarding certain features of the practice in another field, it is not surprising that his opinions are likely to carry little weight and to receive skeptical consideration. Consequently, it may be wishful thinking for a psychiatrist to hope to be heard by obstetricians regarding the emotional factors in pregnancy. Of the many groups of specialists, however, the majority of obstetricians seem more keenly aware of psychological disturbances in their practice, and several have recorded their observations regarding the emotional factors in pregnancy in the literature.[1,2,3,4] The psychiatrists have made some contributions to this subject, but chiefly regarding the so-called puerperal psychoses, an admittedly infrequent complication of pregnancy. In a very few instances there is close cooperation between the obstetrician and the psychiatrist: a personal communication indicates that at Johns Hopkins Hospital such a situation exists; Thompson[5] reported his experiences in the New Haven Hospital Pre-natal Clinic and Hall and Mohr[6] have reported their experiences in the Chicago Welfare Association. In this presentation some of the psychiatric opinions are supplemented by personal communications from more than 100 leading obstetricians from all parts of the country. Not only from the literature but also from these communications one gains the impression that the obstetricians are not only keenly interested in the psychological factors in their patients, but that many seem to take a special interest in the psychiatric aspects of certain problems.

From investigations into the unconscious we have learned that an individual may consciously express one attitude, wish or intention, while he unconsciously harbors an entirely different or even opposite one. Since the individual does function as a total unit we may expect that there will be some evidences, expressed not only psychologically but physically, of the presence of such conflicting wishes. Furthermore, it is a basic assumption that psychological wishes do not necessarily coincide with inherent biological drives. In other words, the fact that a woman may have a biological capacity to bear a child does not mean that she wishes to do so or that she is psychologically capable of doing so in spite of her possible conscious professions that she does. One learns from psychiatric experience that many, many women consciously have no interest or desire ever to have a child; many others have unconscious aversion to pregnancy but express conscious desires based on illogical, immature or even irrational

considerations. In either case, one may expect that the mother or the child or both would suffer during pregnancy and that the conflict would display itself in a total organism reaction, both psychological and physiological.

EMOTIONAL ATTITUDES TOWARDS BECOMING PREGNANT

What is the healthy attitude towards becoming pregnant? Psychiatrists would regard pregnancy as representing the chief goal of feminine psychosexual maturity and the highest type of creativeness. An emotionally healthy woman may feel similarly but may also have other healthy conscious motives for wanting a child—a feeling of obligation to society, a desire to develop a family and home with all its promises of potential happiness and satisfaction; as a method of expressing love for and gratifying one's mate; as the production of an object for the investment of one's love and interest; as an heir to the family name and honor.

Most women on getting married begin to reckon with the possibility or probability of becoming pregnant. Whatever their eventual wishes or plans may be, the threat of possible immediate pregnancy may often be a major factor in determining marital adjustment. Their attitude is necessarily modified by previous sexual information and experience, and very greatly influenced by the character of their sexual relations with the husband. Even for those women who look forward to marriage as a preliminary step to the building of a home and having children, there is often a dread of becoming pregnant as well as a fear that perhaps they cannot become pregnant. The fear of becoming pregnant may be partially justified by reality but in many instances it is unjustifiably magnified or is a rationalization of deeper fears. Often the fear is focussed on the timing of the pregnancy, that it may occur too soon after marriage or too soon after the last child. Often the fear is based on financial insecurity; perhaps the wife is employed and a pregnancy would necessitate her stopping her work. Occasionally the wife may be eager for social pleasures and she is afraid a baby would interfere and cut short her freedom. Sometimes the wife's fear of becoming pregnant is justified by the husband's antagonism or hostile attitude toward a child, for men too may be psychologically immature and regard a child as an intruder although they justify their attitude on some other basis. There are many more such conscious reasons for a woman's not wanting to become pregnant—disharmony and consequent insecurity of the marriage itself, the fear that pregnancy will ruin her health; the disinclination to bring "an innocent child" into a painful world; the fear of responsibility in taking care of the child; the disinclination to forego many pleasures and activities; the fear that she will lose her figure; the fear that the child will ruin her "career," etc. One must presume, however, that

many of these reasons even though expressed by a woman who is apparently a fairly well adjusted individual, are merely rationalizations—attempts to give plausible justifications for negative feelings regarding pregnancy, whereas the fears and negative feelings are actually based mainly on unconscious anxieties and conflicts.

There are some women, both married and unmarried, who appear to the average observer to be fairly well adjusted who have no conscious wish ever to become pregnant, and in fact have a conscious aversion to having a child. From the psychiatric point of view this type of individual is regarded as having rejected in some degree the feminine role and as exhibiting a distorted or immature psychosexual development. One psychological explanation is that such women make an unconscious masculine identification, with such strong masculine strivings that femininity and childbearing are rejected as being incompatible with their psychological makeup.

Just as there are many rationalizations and neurotic reasons for not becoming pregnant, so there are many for becoming pregnant. A woman may consider pregnancy and motherhood as powerful weapons to accomplish certain other ends; she may feel they would provide an escape from an intolerable family or social situation; she may believe that they will bind her husband to her or hold him in the face of other attractions; or she may delude herself with the idea that they will make her husband love her. She may use pregnancy as a means of gaining or insuring support or inheritance.

There are two other attitudes towards pregnancy deserving comment, that of the unmarried woman and the concern regarding sterility. There are some women who consciously want to have a child, but whose economic or marital state precludes pregnancy except at a great sacrifice or defiance of public opinion. Because of the social attitude in this country an unmarried woman is not permitted to fulfill either her biological function or her deep-seated wish, although in the metropolitan cities of Scandinavia this is not the case and in Nazi Germany it has become her loyal and patriotic duty to conceive if she is physically capable of doing so. In American women this fundamental frustration is one major factor in the psychological maladjustment of women.

Some apparently well adjusted women, prior to the first pregnancy, fear that they cannot become pregnant. Perhaps this fear has its basis in the psychological significance of sterility, the woman's inability to carry out her biological function. Most obstetricians do not regard psychological influences as a factor in sterility, although there is a growing opinion among psychiatrists that unconscious wishes may be of considerable importance. Orr[7] has recently reviewed the literature and reported an instance where a pregnancy occurred after three years of attempting to have

a child, with the wife becoming pregnant only after requesting a child for adoption. Three other similar instances are known to the writer: in one instance the wife had had one pregnancy and for several years had tried to have a second child without success; after making application to adopt a child the wife became pregnant with twins. In the second instance the couple had been married for ten years and had apparently been unable to have children. They adopted a child and a year later the wife became pregnant and was successfully delivered. In a third instance the couple had also been married for a period of ten years and during this time had been unable to have a child. They adopted a pair of twins, and shortly thereafter the wife became pregnant; this was followed by three other pregnancies, all successfully completed.

EMOTIONAL ATTITUDES DURING PREGNANCY

Whatever the attitudes towards becoming pregnant may have been, once pregnancy occurs certain emotional stresses may come into play. These will differ widely, depending upon whether the pregnancy is planned and wanted by both parents or whether it is wanted by only one parent or is an accidental and unwished for event. The planned and wanted pregnancy is much more likely to run a smooth course for the mother with the mother also having a more healthy attitude towards the offspring, but much data point to the conclusion that a majority of conceptions occur without intention, many even without being wanted (75 per cent in Thompson's[5] small series).

Probably most parents attempt to reconcile themselves to the pregnancy, but psychiatric experience indicates that a conscious acceptance of the inevitable does not always indicate an ability to adjust to it. Very often one must expect unconscious rejection, as expressed perhaps by excessive vomiting. Even with complete willingness for the role, there are so many changes in the physiological and social life of the woman that no prospective mother escapes from the emotional stresses that result from these changes. There are probably hormonal changes, which even without a tumor in the abdomen, might theoretically account for some emotional variations from the normal. The pronounced readjustments required by this growing tumor—the disturbing of her activities and social relationships, the changes in her relationship to her husband, her wounded pride because of the "deformity"—all are realistic causes for emotional distress. The social status is an important determinant in the intensity of these maladjustments. For the social butterfly the "figure" is all important; for the peasant laborer it is of no importance. In Nazi Germany it is such an honor to bear children for the Fuehrer that any discomfort is supposed to be discounted. However, in our culture, even in the ideal situation of an intelligently de-

sired pregnancy, the woman may be expected to display some transient evidences of rejection or denial of the pregnancy.

In every woman, then, we may expect positive and negative emotional attitudes to express themselves, sometimes fleeting, sometimes prolonged in duration—and these attitudes will be manifested in definite disturbances in her reactions and feelings. The specific reactions and disturbances in any individual case may be understood only in terms of the life situation of that individual. Thus, many women have food idiosyncrasies: certain foods they find repulsive, and other foods they crave inordinately, whereas neither attitude was ever manifested before the pregnancy and both disappear afterwards. Hirst[3] stated that all pregnant women are "anxious" to a degree beyond that of the normal non-pregnant woman. A majority of women become more aware of their physiologic processes—they may notice their heartbeat and wonder if it is normal that they should; the fetal motion is a new physical sensation which may cause alarm; they may experience unaccustomed fatigue. A series of emotional symptoms may manifest themselves: many women are inclined to tearfulness, often without known cause, or others with only the slightest provocation. They are often more sensitive to remarks or rebuffs or criticism than under normal circumstances. Frequently they are more irritable, more critical, more exacting, more demanding. Perhaps the majority express attitudes of self-depreciation; they have lost their attractiveness; their appearance, they feel, threatens the continuance of their husband's love; they may develop a considerable degree of self-pity and even capitalize their "condition" to dramatize it as an irrational (and usually unconscious) method of seeking more attention or demanding more love. The woman may be somewhat the victim of circumstances in this respect, since certainly every husband should be more considerate and protective of his wife in this state. But where his indulgences are excessive (whether through identification or unrecognized guilt feelings) and the wife is fluttered over by a solicitous mother or servants, her neurotic satisfactions may be greatly increased and with them may go possible rejection of her mature role and even of the pregnancy itself.

The majority of well-adjusted women may also be subject to certain anxieties related to their ignorance or misconceptions regarding pregnancy. A surprising number of intelligent women give even more than fleeting credence to various "old wives' tales" and are unduly influenced and alarmed by the sadistic reports of older women regarding their experiences with pregnancy. By a large number of women the period of labor is dreaded for months; they are afraid of what they may do; they fear they will not awaken from "twilight sleep"; the anticipated pain becomes an obsession and the fear of death is not uncommon. Such a list may be much enlarged in the more numerous instances where the pregnancy was not

desired. Well adjusted prospective parents can accept consciously an unwanted pregnancy with few, if any, manifestations of rejection. But even then, for the first thirty to sixty days, they may have many emotional qualms such as indecision regarding the advisability of an abortion, uncertainty as to whether the pregnancy does really exist, concern over the economic threat which it entails and dread of the readjustments required in the activities and relationships of both the prospective mother and father.

On the other hand, many women (and men) may consciously accept the inevitable pregnancy but unconsciously reject it. This rejection may have many motives, psychologically, and may be manifested in many ways unrecognized as such by the individual. The rejection of the pregnancy, which probably always has conscious rationalizations, may on an unconscious basis be related to a rejection of various features or events connected with it, such as conception and even sexual intercourse, the child, or the feminine role. Superficially these may all appear the same and probably in every instance they are entirely unconscious to the woman. That many women unconsciously reject or deny intercourse is well known and is manifested by frigidity in their attitude of passive toleration for it, their ignorance as to their own potential satisfaction to be gained from it, the attitude that it is a duty or obligation which they must accept. That they should respond to it, even with pregnancy, is a psychological inconsistency. The rejection of pregnancy on the basis of rejecting the oncoming child is quite common. Such rejection may be motivated by the woman's reluctance or refusal to accept a mature role; her refusal possibly to give up being the "baby" herself and enjoying the protective and undivided attention of her father-substitute, the husband. Unconscious refusal to accept the feminine role is perhaps the most frequent basis for the rejection of pregnancy. Many women, despite their biological femininity cannot or are not willing to accept psychological femininity. Regardless of what theories one may hold as to the factors in the formation of feminine psychology, whether it be masculine identification, unsolved Oedipal conflict, cultural influences, even the casual observer is aware of the distinctly masculine attitudes or dress or behavior or strivings in certain women. But in all these cases, even though the woman is biologically capable, her psychological refusal makes itself apparent. The individual functions as a total unit—not as two separate entities (physiological femininity and psychological masculinity) and even though entirely unrecognized by herself, a failure of integration will manifest itself in symptoms.

These symptoms may be concerned directly with the course of the pregnancy, the most common being the vomiting occurring during the first months. The vomiting may in some instances be unquestionably toxic in

origin and even in milder cases it cannot be disproved that it has a chemical or hormonal origin. On the other hand, approximately fifty per cent of the obstetricians queried on this question regard it as a psychologically motivated and produced symptom in the great majority of instances. An additional twenty-five per cent of the group regards the psychological factors as contributing a very important influence in the production of the vomiting. Many of these physicians cited evidence to support their opinion: many called attention to the type of individual in which vomiting most often occurs—"the well to do, the intellectual, the college girl." Two physicians mentioned that it practically never appears in Southern negroes. Several mentioned the frequent occurrence of nausea and vomiting in unwanted pregnancies.

Other obstetricians have called attention to the conspicuous precipitating causes: "unhappy home life, too much in-laws, uncooperative husband." One cited a case where the mother-in-law's visit precipitated each attack. The most convincing evidence to these obstetricians, as judged from their reports, is the response to treatment. In the great majority of cases, even quite severe cases, hospitalization with rest and isolation and occasionally mild sedation is adequate and effective treatment. In several instances psychotherapy—particularly suggestion—is the most effective therapeutic measure. In one eastern university hospital, the psychiatrist is requested to see each patient in whom vomiting is a prominent symptom.

Several obstetricians reported that to their knowledge (and possibly experience) certain questionable and admittedly unscientific practices were usually promptly effective in relieving the vomiting: "faked abortion," threatened operative interference, "mishandling the patient with dull needles and tubes." On the basis that the "patient liked neither," one physician reported the free use of venoclysis and hypodermoclysis. Several reported the presence of vomiting in pseudocyesis which stopped promptly on the presentation of positive proof that pregnancy did not exist, and in two reports, it stopped following "a general anesthesia for a faked dilatation and curettage."

Vomiting is a more transparent symptom of rejection of pregnancy than many of the other neurotic symptoms. My brother[8] has outlined many other physical methods by which a woman may unconsciously repudiate her femininity. (In mentioning neurotic symptoms, the psychiatrist does not regard transient appearance of one or even several neurotic symptoms as indicating the presence of a neurosis, any more than rales are justification for the establishing of a diagnosis of pneumonia. In both instances, they are symptoms which indicate pathology.) Any of the so-called normal or common psychological changes noted above—irritability, tearfulness, sensitivity, etc.—may become exaggerated to a severe symptom, often represent-

ing another manifestation of the rejection of the pregnancy. There is no well defined boundary line where these symptoms are merely symptoms and where they may become a neurosis. Certainly, many pregnancies are associated with the development of neuroses: anxiety states, reactive depressions, chronic invalidism and others. A neurosis is often present before the pregnancy occurs and in such instances the neurotic symptoms are nearly always accentuated.

The psychiatrist sees only a small percentage of pregnant or post-partum patients, roughly 5 per cent of his practice. Of this number, according to Boyd,[9] about 6 per cent of the total seen present various types of psychoneuroses; 40 per cent show some type of manic-depressive psychoses; 20 per cent present a schizophrenic picture; 28.5 per cent show a delirious state; and the remainder fall into less common mental diagnostic groups. Of those whom the psychiatrist sees, 14 per cent show a mental disturbance occurring during pregnancy, 54 per cent during the first 14 days post-partum, and 32 per cent are post-puerperal cases. From these patients we have learned much regarding the psychology of pregnancy and particularly regarding the rejection of pregnancy.

Zilboorg[10,11] suggested a particular constellation of personality traits and behavior occurring more frequently in schizophrenic pictures associated with childbirth than in other clinical pictures of schizophrenia. There is often a strong childhood or adolescent attachment to the father which was never psychologically gratified, perhaps due to the personality of the father —his sternness, indifference, or absence. The patient's sexual information and experiences before marriage were meager or non-existent. Masturbation, often excessive, occurred in adolescence and in many instances was continued into married life. Frigidity in marital sexual relations is the rule. With the development of the psychosis, the erotic interest is awakened, sometimes in the mate, not infrequently in homosexual objects. A complete or nearly complete loss of interest in or even hostility for the child is frequent. Anderson[12] and Smalldon[13], two psychiatrists, both have denied the frequency of this picture, but it is not surprising that their descriptive investigation did not bring out the same findings as Zilboorg's psychoanalytic approach. Merely asking an individual whether she has satisfactory sexual relations or failing to observe overt homosexual activity does not serve as an index to the presence or absence of such points. In my own experience, Zilboorg's findings are valid in a majority of instances.

In the clinical picture described above, one must conclude that the individual has never reached psychosexual maturity. She not only rejects the responsibilities of maturity, but also the feminine role and the pregnancy. The homosexual level of development is latent until the psychosis develops. The fact that more than fifty per cent of the psychotic responses occur

during the first 14 days after delivery is especially significant: the actual presence of the child is irrefutable evidence of her feminine role which psychologically she cannot accept.

Perhaps one assumption from these facts is that insufficient attention or heed is given to the importance of frigidity in women. Zilboorg has pointed out that "the sexually frigid man is biologically protected; he becomes impotent and thus avoids that which he wishes to avoid". Moreover, he considers impotence an illness and usually wants to be treated for it. The prevalent opinion with regard to women is that they are usually frigid; that it is not an illness and that they will "get over it"; if they do not get over it, however, they are not relieved by society from the necessity of functioning biologically as if they were not frigid, i.e., impotent.

EMOTIONAL ATTITUDES POST-PARTUM

Fortunately for many women the nine months of pregnancy may be a happy experience. Their acceptance of their future role and responsibilities creates keen anticipation. They display a well-being exceeding their normal health. Their pride in "being two of us" is even increased with the size of the fetus.

But with the post-partum period a new set of trials, unknown and often unexpected, begins. The feeding problem is probably the most common. The psychology of the nursing mother is apart from this study, but the fact remains that in the upper levels of our economic and cultural strata, an increasing number of women do not want to be bothered with nursing a baby. Even a larger group wants to nurse the baby but cannot produce milk. The breach occurring during the shift in management from the obstetrician to the pediatrician may account for some of the problem but the disappointment for the mother and the consequent emotional stress may be great. In the average instance the child now becomes the center of attention rather than the mother. She ceases to be the pampered or considered person and suddenly becomes the servant and slave of the baby. Always must she think of the child first—no longer only of her own wishes and plans. During the pregnancy she could make plans and dream dreams as she puttered in making preparations, but with the arrival of the baby she is almost rudely awakened to find that she has a hard job which has really only started The emotional stresses and strains during this readjustment period are major ones. The acceptance of the maternal role, the sacrifice of her own personal wishes and convenience, the responsibilities of nursing and caring for the baby, the physical effort and taxation—the success with which she is able to accept these is determined largely by her emotional maturity and stability. The degree of success is greatly increased or decreased by the husband's attitude and behavior and his own adjustment to the new arrival in the family.

SUMMARY

An attempt has been made to touch on the more important psychological stresses and strains associated with pregnancy and a few of the manifestations of these. The universality of pregnancy and its importance as one of the major experiences in the life of a woman, both psychologically and physiologically, justify an extensive study from the psychosomatic point of view. Such a study should encompass the attitudes of women, both married and unmarried, towards pregnancy in terms of their individual life experience and situation. Such a study should also include the close cooperation of the obstetrician and psychiatrist in the investigation and management of a large number of pregnant women through the entire course of the pregnancy. And finally, the study should include a close investigation of women during the post-partum state—the woman's struggles with herself and her husband and her baby. Such an approach should be extremely fruitful as a source of material which might be used to aid psychological and physiological adjustment to the reproductive process.

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FUNCTIONAL DISTURBANCES IN THE SEXUAL LIFE OF WOMEN

Frigidity and Related Disorders

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That sexual intercourse should be pleasurable and satisfying to both partners is a proposition to which one would find no disputants among medical men. Gynecologists and psychiatrists especially, however, are aware that perhaps seventy-five per cent of all married women derive little or no pleasure from the sexual act. Many women not only experience no pleasure but actually suffer pain and revulsion. The euphemism "incompatibility" frequently relates to this condition, and countless divorces are traceable to the beginning estrangement between husband and wife who find no sexual pleasure together. Much extra-marital intimacy is similarly to be explained.

This widespread and grave disturbance in the sexual life of women has gained small attention in gynecologic textbooks and journal articles, perhaps because relatively few women present themselves to gynecologists with the complaint of frigidity. Indeed, many women remain in lifelong ignorance of the fact that coitus is supposed to culminate in orgasm for them too, and this ignorance can be sustained in otherwise intelligent women since their role in coitus is relatively passive and requires no "potency" comparable to that required of men. Furthermore, many women who are frequently or regularly frigid but who realize they are supposed to experience pleasure simulate pleasure responses and orgasm in order to please (and deceive) the man.

Intuitive gynecologists may realize that not infrequently women who consult them and request examination on some pretext or other actually want to discover what is the matter with them that they cannot respond and experience pleasure in coitus. The physician who is impatient with psychological considerations will search for abnormalities in size or structure of the genitals or position of the uterus, for inflammations, fissures, ulcerations, injuries and the like and may attribute the frigidity to whatever lesion he finds. Failing to discover anything structurally pathological, he may reassure and dismiss the patient or may devote a few minutes to gynecologic-psychiatric investigation and advice. His crowded waiting-room does not permit more than a few inadequate minutes for this type of management of the case, even if his inclinations would so direct him—and often, unfortunately, they do not. Sometimes, realizing the psychological and emotional nature of the difficulty, he advises the patient to consult a psychiatrist.

Psychiatrists have studied intensively and written extensively about frigidity and the related conditions of dyspareunia, vaginismus, nymphomania and sexual anesthesia. In the course of consultations and treatment sessions for women patients with other presenting complaints such specifically sexual disturbances are very commonly encountered. Most competent specialists in the field of medical psychology arrange to have such patients undergo a thorough gynecologic examination before proceeding with appropriate investigation and treatment of the functional factors. Hitschman and Bergler in their valuable monograph *Frigidity in Women: Its Characteristics and Treatment*[1] state specifically that before psychotherapy is undertaken every case of frigidity should be examined by a gynecologist. Perhaps the time will come when the gynecologist also will advise every such case, in which no relevant organic pathology can be found, to consult a psychiatrist.

Frigidity and dyspareunia are not clinical entities but are symptoms of disturbance of the whole psychosexual development and attitude in the woman. There are, however, degrees and varieties of such disturbances as well as different types of emotional conflicts and psychological mechanisms in their etiology. Various schematic outlines of these have been attempted, and they will be presented in summary. However, in order that they may be more understandable to the non-psychiatrist, I shall first digress into the topic of female developmental psychology. The literature in this field is very large and there are some divergent points of view, but I shall attempt to spare the reader the intricacies of conflicting theories and shall present only the findings which are essential to an understanding of the psychological basis for coital pain, anxiety and lack of pleasure in women.

SOCIOLOGICAL AND CULTURAL FACTORS

For sociological and cultural reasons the female sex is, to a much greater degree than the male sex, hedged about by sexual restrictions and warnings and moral disciplining. Furthermore, female transgressions of these restrictions are more critically regarded than are similar transgressions in males. Prejudices, revulsions and anxieties referable to menstruation, intercourse, pregnancy, childbirth, lactation, child training, female diseases and the menopause are transmitted by older women to girls and younger women all too widely still, although perhaps mental hygiene enlightenment is bringing about a significant reduction in this harmful conditioning. In regard to pre- and extra-marital sexual experiences, the so-called double standard operates heavily against women in comparison with men, imposing grossly unequal social condemnation on women who transgress conventions in ways indiscreet enough to result in scandal. Men who transgress, even

though they be criticized and condemned, still have the benefit of some public indulgence and tolerance, and may even arouse secret envy and admiration from many who would be intolerant of transgressions in women. The protected and prohibition-ridden upbringing of girls according to a rigid and somewhat morbid code of conduct is a powerful factor in producing emotionally unhealthy attitudes, prejudices and fears with respect to sexual enjoyment in girls and women.

PSYCHOSEXUAL FACTORS IN FEMININE DEVELOPMENT

Other potent disturbing factors arise in early female development on the basis of the actual anatomical structure of the female genitals and their differences from those of the male. Without going into the theories too deeply one may state that those who follow Freud's [3,4,5] thinking in regard to female sexuality place the main emphasis on the little girl's reaction to the discovery that she is lacking in an external sexual organ possessed by the boy, so that she believes that she, too, must have once had a penis of which she was punitively deprived by the parents, or that she will somehow be given one or grow one later. Fears, envies, and resentments proceed from the shock of this discovery and initiate the development of conflicting hate and love toward parents, siblings and other significant persons. Distorted sexual theories, neurotic attitudes, personality traits and neurotic symptoms derive from this source.

All investigators agree that these reactions of envy of men and fear of damage to the genitals play at least some part in the psychology of every girl, and that in many cases they are the dominating factors in personality development. Those who disagree with Freud in his formulations regarding female psychology differ mainly in respect to whether or not the primary emphasis should be given to envy based on anatomical differences. They believe that the reaction to sexual differences is secondary, that women's envy of man is based more on the cultural fact of his greater freedom, power and privilege, and that reactions and anxieties referable to the female genitals themselves, without necessarily involving anatomical comparisons, are specific and primary in female psychology. This view does not exclude Freud's formulations, but regards them as secondary and supplemental, not as the crux of female psychosexual attitudes.

Primary biological feminine receptivity (psychologically as well as physically) is believed by the proponents of the latter viewpoint to be based on the anatomical structure and function of the vagina and uterus. Close observation and study of little girls has revealed that they are not, as might appear superficially, oblivious to the vaginal cavity and its sensations. However, an apparent "denial of the vagina" or "lack of discovery" of it comes about as a result of fears of injury and mutilation from introduc-

tion of too large an object—fears which derive from observations of coitus in animals (sometimes of the parents), observations of vaginal bleeding in the menstruation of their older sisters and mothers and in the parturitional bleeding of women and animals, and from the anatomical fact of the vagina's being hidden. Actually the little girl cannot reassure herself regarding the undamaged state of her genitals by ready examination as can the boy who has comparable fears about his genitals. The most easily discovered part of the female genitals, and the one which yields the most pleasure when stimulated, is the penis analogue, the clitoris. Hence it comes about that this genital part has focussed upon it most of the attention and curiosity that the boy centers on his penis. This state of affairs leads to further suppression of awareness of the presence of a vaginal cavity, and paves the way for invidious and traumatic comparisons with the penis and anxieties about presumed past damage or feared future damage to her genitals. Thus the path of development leading to normal pleasurable vaginal sensitivity to stimulation may be short-circuited by the double mechanism of denial of the vagina and concentration of pleasure seeking on the clitoris.

In connection with such distorted theories and anxieties in the little girl her relationships to other individuals also become disturbed and complicated. Her first emotional attachment, like that of the boy, is to the mother, but whereas the normal boy's development thus begins with a heterosexual orientation and proceeds via displacements to sisters, teachers and girl friends, the girl's libidinal orientation must shift from the mother to the father and brothers and then to males outside the family. Hence, from over-attachment to (fixation on) the mother, combined perhaps with envy, fear and hate of boys and men, she may not make this transition and may remain libidinally attached to other females (not necessarily in an overt homosexual fashion). Or the transition may be partially accomplished, with incomplete overcoming of fears and hostilities toward males, so that while social pressure and custom may impel her toward heterosexuality and marriage, the persistent (unconscious) anxieties and conflicts regarding heterosexual activity result in the symptom of frigidity.

These developmental anxieties and conflicts may be further supported by the experience of menstruation, especially if she has been inadequately prepared, by inoculation from her mother and other women with prejudices and additional fears regarding defloration, coitus, pregnancy and childbirth, so that her expectation is one of constant suffering and potential damage to her genitals. The not infrequent newspaper accounts of gang rape and mutilating rape-murders add more fuel to the fires of morbid anxiety and appear to confirm the childhood theory that coitus is a damaging assault on the woman by a cruel man.

That these psychological reactions to anatomical differences between the sexes and fears of mutilating damage to their own genitals occur in some degree in all women is beyond any question. Extensive psychiatric and psychoanalytic experience repeatedly confirms these findings. The reactions ranging from indulgent amusement to sarcastic scoffing among medical men who refuse to make an open-minded survey of the evidence would be soon dispelled if they were able to view psychological matters with the same scientific attitudes which they display toward chemical, physiological and pathological factors.

This somewhat gruesome picture of miscarried feminine development may seem overdrawn or too generally applied in comparison with common observations of the attitudes and behavior of many apparently "normal" women. It must be remembered, however, that most of these fears of mutilation and suffering and hostile envious feelings toward men are *unconscious* and not to be elicited by ordinary interrogation or observation of outward behavior. Only their disguised derivatives may be apparent, the unconscious fantasies and anxieties appearing only in dreams, or in conscious awareness when the psychological defenses break down under stress, and mental illness develops.

TYPES OF REACTION TO SEXUAL ANXIETY

With this background of psychological observation and theory regarding female sexuality, we may now turn to some classifications of mental mechanisms underlying sexual maladjustment in women. Karl Menninger[2] classifies the mechanisms causing frigidity as follows:

A. *The fear of punishment* (for violating sexual prohibitions)

B. *Unconscious resentments and hates* related to

1. A wish for revenge on men, based on a distorted childhood theory which holds men in general responsible for women's suffering and lack of a penis, and the husband in particular responsible for her defloration, her suffering and her lack of pleasure in coitus.
2. A wish to avenge the mother for all the suffering she went through at the hands of the father.
3. Envy of masculine strength, freedom, prerogatives.

C. *Conflicting loves*

1. Love for her father versus love for her husband.
2. Love for women versus love for men.
3. Love of herself versus love for anyone else.

A somewhat different approach gives another classification of reactions to sexual anxiety. Common human reactions to danger from within or from without consist of flight, combat or partial adjustment involving the

choice of the lesser evil. From this point of view one might offer the following classification (modified from Rado[7]):

A. *Flight from heterosexuality*

1. Withdrawal into chastity, with failure to attract men, avoidance of prospective suitors, or beautiful narcissistic self-sufficiency.
2. Masculine identification, characterized by aggressive "old-maidism," competition with men and espousal of causes involving women's rights.
3. Homosexuality, with sexual pleasure limited to overt sexual intimacies with other women and lack of interest in or revulsion toward men.

All of these types are *presumptively* frigid.

B. *Combat—aggressive battling with heterosexual objects*

1. Marriage characterized by aggressive domination of the husband, constant depreciation and humiliation of him before others, the husband of such a woman usually being a weak person who bears the perpetual accusation of his wife that he is "unsatisfactory."
2. "Gold-digging"—aggressive financial exploitation of many sexual partners and husbands.
3. Prostitution, with degradation and infection of many men in a relationship in which pecuniary compensation is the paramount consideration of the woman.
4. Nymphomania—aggressive pursuing and seducing of many men in constant quest of sexual pleasure which is never attained.

All of these types are *actually* frigid.

C. *Partial adjustment; choice of the lesser evil* (a marriage with fairly good outward appearance but with sexual relationships subordinated to other aims in preference to flight or to one of the combat paths under "B". This list does not exhaust the possibilities).

1. Marriage characterized by resignation, suffering and martyrdom.
2. Marriage characterized by absorption in the household and obsessional cleanliness and orderliness.
3. Marriage characterized by extreme inhibition and prudishness on the part of one or both partners so that sexual pleasure as an aim for the woman is considered unseemly and even sinful.
4. Marriage characterized by "glorified motherhood." Numerous children, conceived with indifference and without pleasure, on whom the mother bestows excessive attention and oversolicitousness, the husband being relegated to the background.

5. Marriage with aggressive pursuit of a career and avoidance of pregnancy.
6. Marriage with refusal to assume any serious obligations of wifehood and motherhood; excessive compensatory interest in card-playing, club life, purchasing expensive clothes, sports, traveling alone, etc.

Most women of these types are *relatively* frigid, sexually responsive on rare occasions and then only when certain specific conditions have been satisfied.

FRIGIDITY: DEFINITION AND DEGREES OF DISTURBANCE

Frigidity as a symptom is one of the end results of the anxieties and conflicts described above, and occurs in the marital settings listed in the above classifications. Hitschman and Bergler define frigidity as follows: "Under frigidity we understand the incapacity of woman to have a *vaginal orgasm.* It is of no matter whether the woman is aroused during coitus or remains cold, whether the excitement is weak or strong, whether it breaks off at the beginning or at the end, slowly or suddenly, whether it is dissipated in preliminary acts, or has been lacking from the beginning. The sole criterion of frigidity is the absence of the vaginal orgasm."

Menninger[2] lists the varieties of frigidity as follows:

1. Great aversion (revulsion, disgust, avoidance when possible).
2. Painful submission (dyspareunia).
3. Passive indifference (submission as a wifely duty).
4. Genital anesthesia (interest and seeking of pleasure but inability to feel enough to obtain pleasure).
5. Nymphomania.
6. Associated perversions and fetishism (pleasure depending on specific perverse methods or libidinized objects).

Hitschman and Bergler give a classification based on degree of pleasurable sensitivity in the genitals:

1. *Total frigidity with vaginal anesthesia.* The woman is wholly without interest, there is no trace of vaginal pleasure; feelings of repulsion, disgust and the wish "to get it over with in a hurry." Absence of the lubricating glandular secretion, no sensations in vagina or clitoris during preparatory sexual play; absentmindedness during the act. *Vaginismus* is the *nth* degree of this form of frigidity—fear and active defense, cramp of the sphincter, impossibility of intercourse.

2. *Total frigidity with vaginal hypoesthesia.* Slight excitement at the beginning of coitus, remaining at the same level throughout the act; traces of glandular secretion, a very slight sensitivity of the clitoris. No involuntary muscular contractions.

3. *Relative frigidity with vaginal hypoesthesia.* Relatively strong excitement at the thought and expectation of coitus, but in bed with the immediate prospect of the act, a disappearance of all desire. Remaining conditions as in #2.

4. *Relative frigidity with vaginal sensitivity, but sudden cessation of excitement before orgasm.* Relatively strong excitement, minimal disturbance of vaginal sensitivity, rising excitement until the moment when the involuntary muscular contraction should begin. Then sudden (seldom gradual) cessation of excitement; no orgasm.

5. *Clitoric orgasm with vaginal hypoesthesia.* These women attain a clitoric orgasm in coitus entirely through friction of the clitoris applied by the man for a considerable period of time. No vaginal orgasm, although excitement and glandular secretion are ample.

6. *Frigidity of the nymphomanic type.* Strong excitement, mounting repeatedly, no orgasm. Insatiable seeking after men, and indiscriminate yielding to them.

7. *Obligatory vs. facultative frigidity.* Obligatory frigidity; the disorders described above can occur regularly with all men. Facultative frigidity: they can disappear and permit a normal orgasm with certain men under special conditions.

8. *True frigidity vs. pseudo-frigidity.* Types 1 to 7 inclusive are true frigidity. To be distinguished from them is pseudo-frigidity which is due to ignorance, clinging to false sexual theories, incorrect technique, or some degree of impotence in the man.

9. *Constitutional frigidity.* Aplasias, hypoplasias, the consequences of destructive operations, organic lesions of the genitals, pelvic organs or nervous system, etc. Such organic conditions must be ruled out by the gynecologist before functional disturbances are investigated.

A psychiatric classification of types according to specific psychodynamics, usable mainly by the psychiatrist is also given by Hitschman and Bergler. This classification involves the use of psychoanalytic terms and concepts and will not be reproduced here. The prognosis varies with the diagnostic type, however, and hence such a list of diagnostic types is valuable to the psychotherapist.

PROPHYLAXIS

Prevention of frigidity goes hand in hand with prevention of mental disorders and personality disturbances in general, and is a matter of upbringing and education. In spite of the complicated series of pitfalls, conflicts and fears described above, it is possible for feminine psychosexual development to proceed normally to pleasurable sexual adjustment in

marriage. The following recommendations to parents and educators may be suggested:

1. In general, a home atmosphere characterized by security, affection and tolerance, absence of parental disagreement before the children, consistent giving of affection and enforcing of discipline by both parents to all the children constitutes good prophylaxis against all later emotional and psychosexual disorders.

2. It is particularly important that parents and older siblings do nothing to influence a child of one sex toward behavior and feelings appropriate to the other sex. When the parents have wanted a boy, for example, and instead a girl is born, it is essential that the little girl not be apprised of the parental hopes and regrets in this regard. Also, she should be permitted and encouraged to be normally feminine, and not be "processed" into a tomboy because they would have preferred to have a boy.

3. No matter how difficult the delivery of this girl was (or that of any of the other children) or how near death the mother was during or after childbirth, this story of suffering and miraculous escape from death should never be related to the little girl.

4. The parents, especially the mother, should take a practical, unembarrassed attitude toward matters of bathing, toilet training, childhood masturbation or childhood sexual exposures and experimentation with playmates, so that prudery is not furthered. Parental indignation, intimidation and severe punishment for childhood sexual manifestations do many times more harm than the experiences themselves do.

5. It is probably desirable that children of both sexes be permitted to play about naked and bathe before each other during the first eight or ten years, but childhood observation of the parent of the opposite sex in the nude or during excretory activities has a harmful psychological effect.

6. Children should, if at all possible, sleep alone in rooms of their own. It is always deleterious psychologically for children to sleep in the same bed or same room with the parents, and especially for them to observe or overhear parental coitus.

7. Unembarrassed explanations and preparation for the menarche before it happens should always be made by the mother.

8. Education of the little girl toward chastity can easily be overdone. Repeated warnings against boys and men as nasty, cruel beasts constantly seeking to take advantage of and ruin girls and women are much worse than no education at all.

9. Children's sexual curiosity expressed in questions should always be answered fully and correctly. Children pay more attention to the tone of voice and attitude of the parent doing the explaining than they do toward the information itself.

TREATMENT

Treatment of frigidity and related disorders must depend on diagnosis of the underlying causes:

1. *Constitutional frigidity* (rare; based on actual relevant organic pathology) requires appropriate treatment of the organic lesions.

2. *Pseudo-frigidity* (due to ignorance, incorrect techniques on the part of either or both sexual partners, or to some degree of impotence in the man) may be treated effectively by sexual re-education of both the man and the woman, as indicated. Relative impotence in the man requires diagnosis of the type and treatment of the underlying cause by medical or psychological therapy.

3. *True frigidity* (due to emotional factors) requires psychological investigation, following the gynecological check-up, to determine the degree of disturbance and the dynamic psychological factors operating in the individual case. The gynecologist may attempt re-education and reassurance and if these measures are ineffective, psychotherapy by a psychiatrist or psychoanalyst (preferably a male) should be recommended. Many cases of frigidity carry a good prognosis with appropriate psychotherapy. Some cases, however, are too deeply rooted in neuroses or character disorders or desire for correction is too slight for treatment to be effective.

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PSYCHIATRIC ASPECTS OF CONTRACEPTION

KARL MENNINGER, M.D.

Men and women have always longed for both fertility and sterility, each at its appointed time and in its chosen circumstances. This is the conclusion of a scholarly survey of the medical history of contraception by Norman E. Himes,* which included the study of practices in the various pre-literate societies of Africa and the Pacific Islands, the practices recorded in the papyruses of ancient Egypt and in the Sanskrit records of India, the medical texts of China dating back to 2696 B.C., the medical writings of Greeks, Romans, Japanese and many others.

Contraception, as one of the several forms of population control, "is a social practice of much greater historical antiquity, greater cultural and geographic universality than commonly supposed even by medical and social historians . . . (but) only within the last century do we find any organized, planned effort to help the masses to acquire a knowledge of (scientific) contraception."

During the past five thousand years contraception has been, in part, a popular, non-professional practice and, in part, a medical technique. The tendency in modern times has been to emphasize and expand the latter rather than the former. For this the medical profession should be grateful to Margaret Sanger, herself originally a nurse, who always emphasized the medical aspects of birth control. Two presidents of the American Medical Association, Abraham Jacobi and William A. Pusey, were outspoken in their efforts to convince their colleagues of the responsibilities of the medical profession to further public health by the judicious use of contraception. But it must also be said that not a single medical school until very recently did anything to assist in this program and some physicians have even opposed it. It is significant that the condemnations of contraception have so frequently been expressed with a violence and emotionalism that makes them scarcely entitled to a hearing in scientific circles.

This is not true of all objections to contraception, but it is certainly a problem worthy of psychiatric consideration as to why there should be any objection to it. From the scientific standpoint, *why should any woman have to have a child who does not want to have a child?*

One answer to this is that the question of reproduction is one over which there is a conflict of authority. Some people recognize only the authority of economics; some recognize the authority of public health administration or private health requirements; some recognize a religious authority.

* Baltimore, Williams & Wilkins, 1936.

When these authorities disagree, the people who recognize a dual or treble authority are caught in a dilemma. It is both impractical and unsound for physicians to contradict or belittle one of these other authorities, i.e., the authority of the church or the family pocketbook; these are going to continue to be pre-eminently important to certain people Specifically, the Catholic church objects to contraception and to contraceptive counsel and, insofar as its members are concerned, this is an authority which they must heed. The church may give its reasons for this or not, as it likes.

The scientist, on the other hand, is obligated to give the reasons for his beliefs. As a scientist who believes that contraception, contraceptive counsel and dissemination of information about contraception are desirable from the standpoint of public welfare and personal welfare, I shall give my reasons for so believing.

There are the well known reasons which pertain to the question of maternal health and infant morbidity. There are certainly some women who are well enough to have sexual intercourse but not well enough to bear children, and it would seem to me that the health of such women should be safeguarded without forcing them to be continent and without forcing their husbands to choose between continence and adultery. There are other women who cannot bring healthy children into the world and it would seem obvious that they should not be obliged or even permitted to bring unhealthy children into the world. A further discussion of these reasons I shall leave to gynecologists, internists and pediatricians.

There are, in addition to these reasons, certain aspects of the birth control problem which come into the field of psychiatry, aspects which are less frequently emphasized and perhaps less fully appreciated, which supply further reasons for supporting a birth control and planned parenthood program. These I should like to elaborate somewhat.

(1) Clinical experience brings us as psychiatrists to the very definite conclusion that while in the lower animals sexual pleasure is primarily a means to an end, in human beings it is not only a means to an end but also a very important end in itself. With a much more elaborate central nervous system and a far more complicated social environment, the human being no longer reacts as animals do in a simple reflex way to the sensory indications of a reproductive opportunity. The impulse for sexual union travels a long, complicated path and becomes entwined, as Havelock Ellis says, with all the highest and subtlest human emotions and activities, with the refinements of social intercourse in every sphere, with art, with religion, with all the facets of that which we call love between human beings. The thwarting of this means the interference with productivity and creativeness in all spheres and the interference with the harmony of human affection which law, religion and social custom are at such pains to nurture.

In the early days of sex instruction it was felt desirable to protect the youth against the supposed dangers of masturbation and the real dangers of venereal disease by assuring them that there was "no evidence that continence is physically harmful." The lives of many noble spinster school teachers and bachelor priests were pointed to as examples of the healthfulness of self-restraint and this was in line with the general idea that sex in itself was a necessary evil or a very specialized pleasure reserved for those old enough and economically secure enough and socially fortunate enough to be able to marry. Strictly speaking, the quotation is true, but in its inferences it is untrue and I regard it as intellectually dishonest to continue to use it to foster hypocrisy, false attitudes and neuroses. Solitary confinement is not *physically* harmful either, but it is harmful to the personality in other respects and everyone knows it, and the same is true of complete continence in the adult, male or female All psychiatric experience confirms the view that the boy who refrains from masturbation out of fear and guilt is more unstable, more subject to physical and nervous breakdowns, more likely to develop character disturbances than is the boy who is able to masturbate without guilt or to control such guilt feelings as masturbation arouses in him. Sexual intercourse is not identical with masturbation by any means but, in the normal course of events, the love of oneself and the obtaining of gratification from the self as in masturbation is replaced by the love of someone else and with it the pleasure of sexual communion with that person. Denied the latter outlet, the suppressed energies become diffused, distorted and capable of pathological expression. To prevent the latter requires much psychological energy—we call it self-control. Freud said that the truly moral man is one who feels temptation but resists it. But such morality is put to severe tests by the barest facts of civilization—economic facts, social facts, the present problem of husband and wife seperation in the war and many other unavoidable realities. To this there should certainly not be added the artificial barrier of ignorance. For this reason, contraceptive knowledge should assuredly be in the possession of every adult. If there are medical, moral or religious reasons why he should not use that knowledge, that is another question. For ignorance, for lack of knowledge, for lack of facilities and counsel, there is in this enlightened century no excuse whatsoever.

(2) The reason that contraceptive knowledge and counsel seem to the psychiatrist to be essential is based not upon considerations of the welfare of the adult but upon the considerations of the welfare of the child. Nothing is more tragic, more fateful in its ultimate consequences, than the realization by a child that he was unwanted. Where one child reacts to this in later life with an acute mental illness, dozens of children (as I have said elsewhere) react to it in more subtle ways by developing self-protective

barriers against the inner perception of the feeling of being unwanted. This may show itself in a determined campaign or in a provocative program of attracting attention by offensive behavior and even criminal acts. Still more seriously it may show itself as a constant fear of other people or as a bitter prejudice against individuals or groups through deep-seated, easily evoked hatred for them. The rage of the southern poor white against the Negro suspected of some dereliction is referable to the hate he feels inwardly at having been himself, like the Negro, unwanted. The same is perhaps true in the case of Germans and Jews and in many other situations which give opportunity for expression of hatred in the denial of the feeling of being rejected. The importance of this factor in the psychology of war is even greater, in my opinion, than the economic factor arising from the increase of population. This is why I say that from the purely scientific point of view, planned parenthood is an essential element in any program for increased mental health and for human peace and happiness. The unwanted child becomes the undesirable citizen, the willing cannon-fodder for wars of hate and prejudice.

This point seems to me to be a very important one, and I have elaborated it in my book *Love against Hate** in connection with a discussion of possible means for ameliorating the gloom and hate filled world of today. The text there proceeds as follows:

> By planned parenthood I mean parenthood entered into willingly, with adequate preparation for the strains and sacrifices it imposes, with sufficient means and equipment to give the child a healthy start in the world without depriving others of the actual necessities of life. It means, too, sufficient psychological maturity and understanding on the part of the parents to endure the dependency of the child over a period of many years. Of course, every thinking person approaches parenthood with some fears, but these are quite different from the acute protest with which many children are received today, often quite justifiably. . . . The children of the future do not "belong" to their parents alone: they are the concern of every one of us; they are *literally* the hope of the world.
>
> It is only fair to admit that the feeling of being unwanted is not always discoverable in the psychology of children who nevertheless were very much unwanted at the time of their conception. Thoughtful religious objectors to birth control make two points here: First, they say that if parents are educated to believe that it is unrighteous and opposed to the will of God for them to entertain any resentment against pregnancy, such hostilities will not develop consciously in the mother, and hence the child will be spared them; secondly, they maintain that even parents who are unable to overcome their resentment during pregnancy forget it completely when the child is actually born or when he grows older, and hence the child never feels any such effects.
>
> As to the first point, I agree that it is possible to make people believe it sinful for them not to have a child, even when having another child will make them and their other children more distressed and frantic. I agree that this is possible, and I agree

* Harcourt, Brace and Co., N. Y., December, 1942, pp. 224 ff.

that it is being practiced. But repressing or suppressing conscious resentment does not mean eliminating it. A deliberate program of enforced attitudes, backed up by pious references to the will of God, accomplishes its results only at the expense of inner conflict and real suffering.

The second objection, that parents often overcome their initial resentment against pregnancy and realize that they *do* want a child, and learn to love it, is a more weighty argument, I think. The conception and nurture of a child—or several, or (if possible) many children—is of paramount importance in mental health. The considerable renunciation of these satisfactions which civilization has made necessary is a menace to its very continuance.

"But if you admit this," continue the objectors, "you will also admit that some couples, who would be benefited by having children, reject or defer the idea and thus self-destructively deny themselves and the world what it would be better if they had no power to prevent. There will be vast numbers of people who will say, 'Yes, we want a baby, we want children, but not now. We are not quite ready; it isn't just the moment.' And for some the right moment never comes; they never become parents, and this is not good for them or for the world. Who would decide when the birth of a child might do more harm than good?"

I think this question has a very clear and direct answer; that the parents themselves can and must and will determine the solution best for them. It is well known that many intelligent people, including many Catholics, have known about and used contraceptive techniques for a long time and that this has not resulted in an increase of childless families, as has been shown by carefully collected statistics available to anyone. In Sweden, public enlightenment in regard to such techniques is said to have resulted in an *increase* in births in certain parts of the population. The wish for a child which so strongly dominates every woman will not allow specious arguments to deter her from obtaining this gratification if it be a reasonable possibility—and I refer not only to economic and physical possibilities but to psychological possibilities as well. The decision may be made unconsciously, but it will be made; and it can be safely left to those for whom during the subsequent years the child will be a primary responsibility. If it is not made, one may be assured that the resistances were so great as to act as danger signals so urgent that they could not be ignored. In fact, the opposite often happens: the impulse to have a child is so strong that parents often go beyond their emotional strength to have it, so that a "wanted" child may subsequently become unwanted.

If child-rearing were accorded its deserved importance in human life—if parents, and those who are to become parents, regarded their children as their highest achievement, giving them the best possible environment and training—then the failure to conceive among persons physiologically and economically capable of it would be regarded as evidence of a neurosis, an inhibition requiring treatment. Such a hypothesis would imply that parenthood, instead of being left to chance, ought to be a careful and deliberate choice dictated by intelligence, the same intelligence that must be used in the treatment of those neurotic failures who cannot bring themselves to enjoy children—who perhaps cannot enjoy anything.

These are the reasons for contraception that appeal to the psychiatrist, reasons now submitted to those gynecologists and obstetricians who in their daily practice have far more occasion than the psychiatrist to supply the information or the counsel needed. As I said above, they are not the only reasons; they are reasons offered as a contribution to the medical consensus.

SUGGESTIONS FOR THE PSYCHOLOGICAL STUDY OF STERILITY IN WOMEN

LEWIS L. ROBBINS, M.D.*

Although pregnancy is a much investigated process and despite the fact that the science of obstetrics has advanced greatly in the past fifty years, some of the fundamental questions regarding just what happens when a woman becomes pregnant remain unanswered. That psychiatrists should think that the emotional state of a woman influences conception would probably seem unimportant to gynecologists, were it not for its application to the widespread problem of sterility.

One of the advancing frontiers of medicine today is the field of psychosomatic investigation; that discipline which recognizes that psychic and somatic phenomena are different aspects of the same thing. As discussed elsewhere in this symposium, because of the interrelationship between psyche and soma, not only is the psychic life influenced by changes in the somatic being, but psychic influences can also alter the somatic state. Emotional conflicts can result in somatic dysfunctions and psychological therapy is often able to effect improvement in such dysfunctions. That this is equally true of the generative functions as well as of other physiological processes seems inevitable.

A promising opening for psychologically oriented investigations of problems relative to conception is the well-known phenomenon of conception occurring in a previously sterile woman after she has adopted a child. Many women do not conceive although no organic basis for this disability can be found. With some change in the life situation of some of these women (for example after adoption of a child) but without discernible changes in their structure or physiology they become able to conceive. This has become common knowledge to the extent that married couples about to adopt a child often hear predictions to the effect that they will now have a child of their own. Unfortunately, accurate statistics of the frequency of such events are not available but inasmuch as almost everyone knows of one or two such incidents they must occur rather frequently.

Common experience and observation seem to agree here with the psychosomatic viewpoint that psychological factors may play a significant role in the ability of a woman to conceive.

The scant literature on this subject has recently been reviewed by Douglass W. Orr[8], who has contributed probably the first careful psychological study of a childless married couple who had a child of their own

* Now stationed at Brookley Field, Alabama; Lieut. M. C.

shortly after the decision to adopt. The literature consists mainly of discussions of the possibility that sterility may be psychogenic. The views of A. Mayer[5], Sellheim[9] and Mohr[7] are summed up by Dunbar[3] as follows:

> . . . that psychic influences, associated with a vivid but unsatisfied desire for a child, may stimulate the ovaries to pathological growth. It is possible that this may result in premature maturation of the follicles and discharge of ova which are not yet ready for fertilization, and consequent sterility. That the peculiar cases of first conception after fifteen or twenty years of married life may be explained by the fact that as a woman becomes gradually reconciled to her sterility this injurious influence on the follicular apparatus disappears (p. 341).
>
> In view of the variety of mechanical and chemical (chiefly endocrinological) processes involved in conception, it is *a priori* almost impossible that psychic factors should not play a role. Furthermore, the influence of psychic factors on the endocrines is sufficiently proven . . . thus giving additional justification for the belief that psychically influenced hormonal processes may play a role in conception. According to Sellheim, we have to reckon with the possibility of a postponement of ovulation (or the opposite), since with all emotions there is a marked change in abdominal circulation. This, however, is synonymous with the possibility of favoring or hindering conception (pp. 341–342).

Menninger[6] in discussing the unconscious repudiation of femininity in women made reference to Sellheim's work and concluded that the premature maturation of the follicles resulting from hyperactivity of the ovaries may "in some cases, be cured by psychotherapy, in others by a gradual reconciliation of the woman to her sterility, this reconciliation serving to decrease the pathological (emotional) stimulation of the ovary and hence allowing it to discharge normal ova and to terminate the sterility, as when a child is born after a couple has adopted one." (p. 522.)

Knight[4] also discusses functional sterility in an article dealing with problems of selecting and rearing adopted children, as follows:

> Since it not infrequently happens that a childless wife does become pregnant some time *after adopting a child*, although the adoption did not take place until the couple were thoroughly convinced conception was impossible, one is led to theorize that unconscious opposition to child-bearing might have been responsible for the functional sterility, and that this unconscious opposition was somehow overcome by the experience of adopting and taking care of a child. How the unconscious opposition to child-bearing might have operated to thwart the conscious attempts to achieve conception is a moot question. One possible hypothesis is that the unconscious of the woman, . . . may affect the physiology of ovulation or implantation in such a way as to prevent conception. Another hypothesis is that there is an unconscious awareness in the woman of the time and fact of ovulation and that she manages to avoid coitus at the critical period (p. 66).

The recent studies of Benedek and Rubenstein[1,2] further suggest that psychological factors influence the gonadal functions. Orr[8] summarizes Benedek's views as follows:

There is a definite interrelation between the psychosexual development of the individual and the hormonal cycles so that psychosexual fixations or inhibitions may lead to irregularities of the gonadal cycles producing a psychosomatic vicious circle (p. 442).

In order to indicate more definitely some possible relations between sterility and psychological factors, the only thoroughly investigated case reported in the literature will be reviewed here in detail. In this case, reported by Orr[8] both husband and wife had been psychoanalyzed. In the husband's analysis he showed no evidence of unusual anxiety or hostility to fatherhood but did display a need to remain emotionally dependent on his wife (as a parent figure) and had encouraged her to continue working which she keenly resented. Her analysis indicated that the fact she was not permitted by her parents to be feminine was the nucleus of her conflict. Her parents had wanted a son and had treated her as a boy, dressing her in tailored clothes, praising her boyish figure and encouraging her to engage in athletics and play golf with her father. Emphasis was also placed upon her being independent and self-supporting which she associated with masculinity. When, after her marriage, she was compelled to continue working and was encouraged to do so by her husband, she found herself in a situation similar to that in which she had been before marriage, with her husband now assuming the role formerly played by her father.

If she had stopped working outside the home, she would have felt guilty toward her husband, and even though they both consciously wished to have a child, she could not become pregnant while she was working because through her work she was still endeavoring, unconsciously, to carry out the masculine role which had been urged upon her.

Their decision to adopt a baby on a definite date made it necessary for her to give up her job and this action decreased her hostility toward her husband and her dissatisfaction with herself in the masculine role. The encouragement given to her formerly depreciated femininity seemed to bring about a rapid change, inasmuch as she became pregnant within a few weeks after giving up her job and assuming the care of the adopted child.

This is but one case of apparent sterility in which the psychological material has been adequately studied and reported: thousands of similar cases exist but have not been studied from this point of view. When a previously childless couple have a child of their own after making the decision to adopt one, the probability of psychological factors being present in causing the previous infertility is more apparent than in those cases of childlessness in which no event occurs to demonstrate possible psychological factors. In these instances, we can only postulate the existence of such unconscious factors.

In many childless couples, the wife is an extremely infantile individual who never gives up the father-daughter relationship but continues it in her marriage in relation to her husband. The unconscious desire to maintain this situation which would be upset by the presence of a child may in some way operate to preclude pregnancy. Such infantile women not infrequently have infantile or underdeveloped genital organs. Another type of psychological constellation in childless couples is one in which the wife is the dominant figure assuming a masculine role which pregnancy and motherhood would destroy. It seems probable that there are other cases in which the hostility of the wife toward the husband is the primary factor in the infertility. This may account for some instances in which a woman is sterile in one marriage but conceives in a later marriage.

The scope of this paper does not include the problem of sterility in the male but this, like its feminine counterpart, offers an almost untouched opportunity for psychological study.

Scientific techniques have now advanced to the point where the psychological aspects of such problems as sterility can be scientifically studied. In order for further knowledge of this common difficulty to be obtained we must look to obstetricians and gynecologists to whom people come for help in these matters. With careful, simultaneous organic and psychological studies, the interrelationships between fertility and emotional states can be fruitfully explored.

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MENARCHE AFTER ONE PSYCHOTHERAPEUTIC INTERVIEW: A CASE REPORT

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Many case reports have been published dealing with the influence of psychological factors on cessation of menses, irregular menses, and related phases of such problems, but to my knowledge cases wherein the first menstrual period seems to have been brought on by psychological factors are rare. Quite a good deal is known about how girls react to their first menstrual period, but in most instances, little comes out of detailed studies which seem to indicate that psychological factors were important as to the exact time the first menstrual period occurred. The time seems, if anything, more biologically than psychologically determined. The following case presents some evidence that the menarche may be delayed for emotional reasons. This is not at all surprising, but it is a bit unusual that a single psychotherapeutic interview should have brought on menstruation in a way that seems not entirely a coincidence.

A fifteen-year-old girl was brought to the Neuropsychiatric division of the Topeka Municipal Clinic for treatment of a long-standing depression. Her history as given by a social worker is as follows. The patient's mother had been burned to death in an accident when the patient was six years old. The father reared the patient and her older brother for four years, and then remarried. When the patient was 12 her father died, and the stepmother began to show considerable irritability toward the children who were not hers. The Kansas Children's Home and Service League took over the care of the children, and the patient lived in the receiving home for three years. She had always been an unusually quiet and asocial girl, working much harder than was expected of her, never seeming to rest, and always looking for more work to do. She assisted in taking care of other children, cooking, and cleaning, and at the same time continued a full school schedule. From time to time she had been observed crying quietly in bed before going to sleep but when questioned about it she denied that anything was the matter. Her social worker had tried for about five months to get her to see a psychiatrist, but she always refused, stating that she didn't need any help. During Christmas vacation in 1937 her brother insisted that she visit their grandmother. Upon her return from the visit she was obviously more upset because she had been shown pictures of her parents. Her crying spells increased, she had some night terrors, and finally agreed to come to the clinic to see what might be done for her.

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The first impression the patient gave in an interview was of being extremely compliant, gracious, and acquiescent, smiling all the time, and trying to deny in as graceful a way as possible that there was anything the matter with her. She was so reluctant to talk about any of her symptoms that the major part of the first interview was taken up with a discussion of her general health and her school work. She denied having any concern about herself, but when asked if she had begun to menstruate yet, she said that she had not, and hastened to add that she was not worried about this, since she had been told all about it, and that it had been explained to her that some girls menstruate later than others. I asked her why she made such a point of assuring me that she was not concerned about it. She replied that I probably had some opinion that she was different from other girls. I assured her that I had no such opinion, and told her that it was very likely that she would begin to menstruate soon. That night her first menstrual period began.

Thereafter the patient was very much improved. She became cheerful, more sociable, less compulsive, and talked rather freely about her previous emotional upset. In brief, it was she who thought she was different from other girls. She had many guilt feelings dating from the age of six at the time of the death of her mother. These were very vague, and the only verbal expression she could give them was that in some way she might have been responsible for her mother's death. These feelings did not disturb her, however, until she was rejected by her step-mother after her father's death. Again she felt she was responsible in some way for not being loved. For three years, especially at night, she had many suicidal fantasies and dreams of being killed.

Unfortunately, not enough is known to answer many questions in connection with the mechanisms involved. For some reason her social worker, who was most sympathetic and understanding, could not reassure her sufficiently against her guilt feelings. The initial interview she had at the clinic served the purpose of releasing the tension psychologically and at the same time bring on the menarche. The type of relief of tension which this patient felt is very similar to the more common one observed by many women who experience a building up of pre-menstrual tension with release of that tension as soon as they begin to menstruate.

EMOTIONAL FACTORS IN ORGANIC GYNECOLOGICAL CONDITIONS

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The afflictions for which women go to gynecologists can be classified as of three types: (1) those which the gynecologist knows immediately to be non-organic, functional, "psychogenic"—e.g., sexual frigidity; (2) those which the gynecologist recognizes as arising from a mixture of organic and emotional factors, such as the ever familiar "pain in the side" and dysmenorrhea; (3) those which have a definite and obvious structural pathology, such as prolapse and fibroids, in the etiology of which psychological factors are usually not regarded as even possible.

The preceding articles in this issue of the *Bulletin*, written by my colleagues, have dealt with the psychological factors in the first two types. I wish to discuss the possibility that psychological factors may contribute to the disease picture in gynecological conditions which are definitely organic and in which structural pathology is clearly evident, the third type mentioned above.

Some time ago I attended one of the regular monthly staff meetings of a general hospital with no expectation of hearing anything of special psychiatric interest. As a matter of routine, a gynecological colleague presented the case of a 38-year-old primipara who bled to death rather suddenly after the uneventful delivery of a healthy child. There was a long discussion by members of the staff regarding the possible cause of death in post partum hemorrhage. The discussion led to no conclusions as to why this woman should have died. It was emphasized that there was a very small loss of blood and that prompt and appropriate treatment had been given by the physician in charge and several associates.

I had become interested in the case by this time and I asked the following questions:

(1) Had the woman wanted this child? The colleague who had presented the case may have thought this a rather irrelevant question but answered that, so far as he knew, she had. He had not remembered her having said anything to the contrary.

(2) Why had this woman, 38 years old, never become pregnant before? My colleague thought this question also somewhat irrelevant; he could only answer that he did not know.

(3) If the patient had wanted a child, had she ever made previous efforts to have one or to have her apparent sterility investigated or relieved? My colleague believed not.

It seemed to me that there was much to support a hypothesis that for

some reason or another this woman had not wanted a child at this time or at any previous time, and that her becoming pregnant in this instance was for her an intensely critical and significant event. We know from psychiatric experience that many neurotic women go through years of agonizing conflict over whether or not they should have or may have children. Some of them have an intense phobia of pregnancy, a feeling that to become pregnant or to have a child would be the death of them. I treated one doctor's wife, for example, who had denied him sexual access to her for fifteen years, in spite of intense passionate longing on both her part and his, because of her fear that she would die if she became pregnant. I know of another woman whose fear of pregnancy was so great that following a sexual relationship which was very abortive and incomplete, she demanded that her husband kill her in some painless way rather than that she be tortured by the agonies of death in childbirth, which she was certain would follow. In both of these women the fears of pregnancy were very conscious; in many other women, the fear is unconscious and is expressed only in a strong aversion to pregnancy or child-bearing against which they take more practical precautions.

I expressed myself along these lines to the staff, suggesting further that this woman's death might have been the result of powerful death wishes, mostly, but perhaps not altogether, unconscious, and I asked my colleague if he could find any evidence along these lines from discussion with the husband. I expected him and the rest of the staff to be highly incredulous, but, to my astonishment, the obstetrical colleague arose to say he had been very much impressed with the comment and now recalled something which, in scientific honesty, he felt he should report. This was the fact that it had been discovered *after* the woman's death that there was some evidence that she had anticipated that she would die. He was very interested in the suggestion that we get more information and the services of a social worker were, fortunately, obtainable and this is what we learned.

The patient had always been an ambitious business woman who had never wanted to become pregnant. She had "never given child-bearing a thought," a description manifestly untrue but indicative of an unusual attitude for a normal, married woman. When, after these many years of childlessness, she found herself pregnant she was greatly upset, and for a long time she refused to accept the fact, believing herself to be in the menopause. When gradually it became an undeniable fact, she was very bitter; there was unverified information to the effect that she had considered having an abortion. She kept her job as long as possible and resigned it only with great reluctance a few months before delivery. Just prior to going to the hospital, she had made out a will and had given her husband specific instructions as to what to do with the baby. She wrote out the

names, male and female, that she wished it to have. Following her death, several of the friends who knew her intimately expressed themselves as not having been at all surprised that she died, since so many of her actions and remarks seemed to point to the fact that she had expected it.

Let me repeat that I recognize that this case does not prove anything, but in scientific work, as Huxley said, "those who refuse to go beyond fact rarely get as far as fact." A patient who had fought with herself for years against having a child finally became pregnant, reacted with resentment, fear and resignation and planned for the possibility of her death, bore the child and died under circumstances that baffled the physicians. If this woman had had pneumonia and at the height of the pneumonia had said, "I do not want to get well," this expression of her emotional attitudes would have been taken seriously by her physician had he been a man of experience. As it was, she was "afflicted" not with pneumonia but with pregnancy, a supposedly normal physiological condition but a condition which was totally incompatible with this woman's personality structure.

Let us leave such dramatic problems as death and hemorrhage and consider the prosaic question of muscular tensions and relaxations in the surgical floor and pelvic contents. The old theory that displacement of the womb (hyster) was the cause of nervous diseases, particularly hysteria, which could sometimes be corrected by giving such drugs as the valerianates, the particular flavor of which would drive the womb elsewhere, have long since been discarded. Nevertheless, medical practice today still tolerates to an incredible extent the attempts at relieving nervous women by correcting uterine displacements.

One should not be too quick to ascribe this to the ignorance or carelessness of the gynecologists. Surgical operations, even unnecessary ones, do sometimes cure nervous diseases, not for physiological or anatomical reasons but for deep psychological reasons which I have analyzed in some detail. (See *Man Against Himself*, pp. 297 to 317.) The closer an operation approaches the genital zone, connected as it so often is with strong guilt feelings, the greater the likelihood that (temporary) relief from anxiety, and therefore from nervous symptoms, could be expected to follow such a "punishment." To obtain such an operation, a patient must first manage to focus surgical attention upon the pelvic organs, because it is no longer accepted practice to subject a woman to hysterectomy for no reason whatsoever except to cure "nervousness."

Physicians and surgeons, like other people, are apt to indulge in rationalizations, i.e., to give themselves explanations that seem to justify an act but which do not really clarify the motives leading to it. We can easily be led to exaggerate the degree or importance of flexions and versions and to read abnormalities into signs and symptoms related to the uterus, espe-

cially if the patient "presents her case" well. The surgeon must depend to a certain extent upon what he is told by the patient, and the average surgeon depends even more upon what he feels with his hands and sees with his eyes than upon what he hears with his ears. There is no doubt but that some women have abnormally relaxed pelvic musculature, an abnormality which, in the surgeon's mind, is never functional because it is apparent as a structural breakdown affecting involuntary smooth muscle tissue, not ordinarily regarded as being controlled to any large extent by conscious nerve impulses. Of course it is well known that there is a certain conscious and voluntary control of the musculature of the pelvic floor which can be utilized at any time and which is very important during parturition, defecation and coitus, and we know, of course, that the tone of the pelvic floor, like the tone of any other musculature, is kept intact by a constant flow of nervous impulses. If this floor is relaxed, or if the smooth muscles supporting the uterus in its normal position relax, it must be due to some interference with the maintenance of this tone, i.e., with the normally maintained supply of nervous impulses.*

The problem which these considerations arouse in the mind of the psychiatrist is how to explain the psychological background which would demand a gynecological expression of this sort for the satisfaction of some intrapsychic tension. Why should the sexual organs and their supportive structures which are so necessary, so fundamental, so primitive, get out of order so frequently in civilized life? Allied to this is the question as to why should women develop such unnatural conditions as frigidity and vaginismus.

Freud was not the first to point an answer to these questions but he was more systematic and scientific than others in his demonstration of how civilization causes sexual repression and vice versa. One plain fact well known to every physician is that the sexual organs and the sexual life generally are under the influence of a strong taboo, such that guilty feelings are apt to be associated with activities relating to the genital organs, even when those activities are entirely harmless. Masturbation is not the only example of this; in the mind of the growing child there are all sorts of fantasies, with or without masturbation, that lead to a psychological interpretation of sexuality quite different from that which the healthy minded physician, unacquainted with psychology, is apt to assume exists in the mind of his patient. I am trying to say that the average gynecologist forgets that the patient whose genital organs seem to be "wrong" actually is apt to be a patient whose psychological processes relating to sex are "wrong." The latter can definitely influence the former.

* In this I am entirely omitting traumatic results of childbirth which may cause a local injury to the nerve fibers supplying this musculature.

Take the following case, e.g., reported by a colleague:[1] A woman of 27 had been married for six years. She came to her physician because of dragging sensations in the perineum; she had no "power" to expel faeces and had become severely constipated. In addition, she had a prolapse and had been treated with douches, pessaries, pads, etc. (without relief) until she had become convinced that treatment was useless.

Because of these facts my colleague did not institute gynecological treatment; instead he began psychotherapeutic treatment. Very early it was learned that from the time of her marriage she had had a horror of sexual relations, so much so that intercourse had been practically suspended during the first few years. She feared constantly something terrible would happen to herself and her husband if they had intercourse. As fate (?) would have it, she became pregnant in spite of their infrequent intercourse, and the child died shortly after birth. She then concluded that she must have suffocated it in utero, perhaps by pressing on the umbilical cord through the rectum when she took her enemas. This revived or increased her dread of sexual relations and she began to suffer acutely from bearing down pains, heavy dragging sensations in the legs, etc. As her psychoanalysis proceeded, it was discovered that back of the fear of having done damage with the enema point was the fear that she would injure her husband's penis by some contraction of the vagina. Any activity of the pelvic floor was sufficient to evoke these terrible fantasies whether the activity was in sexual intercourse or in the contraction of the pelvic muscles when at stool. She felt it "terribly wrong" to move these parts in any way actively or passively. She tried constantly, first voluntarily and later involuntarily, to allow her pelvic musculature to be totally relaxed, motionless, semi-paralyzed. This, of course, encouraged constipation which, in turn, contributed to the pelvic dragging; a vicious circle was set up in which the pelvic relaxation became prolapse.

In such cases as this, of which there are others on record, and examples of which I have myself studied, I am quite certain that hypotonic pelvic musculature can be related to psychological factors. The sensation of prolapse without the visible appearance of any prolapse is, I am informed, a common gynecological condition. Mayer[2] states that "the phenomenon is to be explained either by hyperemia of the organs with consequent pressure downwards, or by a decrease in the tonus of the smooth musculature, that is, a sort of readiness of the vagina to receive or expel something (Walthard), this being experienced as gaping of the introitus. Such a decrease in tonus is not surprising, because we are familiar with the opposite, an increase in tonus (in the case of vaginismus) as an expression of strong emotion."[3]

I do not know to what extent cystoceles depend upon hypotonic mus-

culature. A case has been reported* of a woman who had a cystocele so large that it was impossible for her to have sexual intercourse or to play at various sports such as golf. One obstetrician had recommended a suspension of the uterus, another recommended a pessary which the patient wore a few weeks and then discarded. For other reasons, the patient underwent psychoanalytic treatment and over a year later, during which time she had no gynecological treatments, it was suggested that she have this condition checked by an obstetrician. This was done and the obstetrician told her that it was remarkable to what extent the tone of her pelvic musculature had improved. He found it difficult to believe she had ever had a cystocele.

It is easy to understand how labor can be particularly difficult and traumatic to women whose pelvic musculature is in a state of disordered tonus as a result of emotional factors involving sexual conflicts. Rickman (op. cit.) comments that we are apt to assume that pregnancy and parturition are such normal processes that they are uncomplicated by hysterical manifestations when common experience is quite to the contrary. During normal labor the "uterine contractions exert a force proportional to the resistance of the lower genital canal; 'the perineum is able to bear all the force *instinctively* exerted without injury,' as Denman wrote nearly a hundred years ago; but if the woman, from excitement or from pain, begins to use all her force to end the labour speedily we know that there is grave risk of laceration of the perineum. At this juncture, if the diagnosis of a normal presentation has been made, and the course has been regular, the obstetrician begins to render active assistance; he calms the patient, and directs her when to exert force and when to desist. In other terms, he supplies the allo-erotic element required to make a unified psychosexual response to the genital stimulus. For this reason no doubt many women who would choose a gynecologist of their own sex prefer a male obstetrician. Some women in labour behave 'hysterically,' as the saying goes; they exert their force at the wrong time and do not respond to the advice of the physician, they do not take the tempo of their voluntary exertions from the rhythm of the uterine contractions nor from the bidding of their obstetrician. . . . Disregarding injury and extra pain, she behaves regressively, expelling the child as she expels faeces, with force and without delicacy. One writer[4] has found a correlation between laceration of the perineum, 'abnormal resistance' and vaginismus, one which supports the theoretical view here put forward."[1]

These psychoanalytic observations are confirmed by the comments of a thoughtful and observant general practitioner[5] who has published his impressions and theories relating to this same theme.

* I regret to say that I have misplaced the reference to this case report.

"These women having hypertonic (muscular)* action through (impulses coming via) the thoracico-lumbar nerves have the *os uteri* closed . . . during (pregnant) distension, with little resistance. There may be hypermesis during the first few weeks of pregnancy; but, if there is no injury from external cause, there is little danger from miscarriage. However, if there is injury, causing miscarriage, the delivery is usually tedious with slow dilatation on account of the tonic state of the os. Most of these cases require an anaesthetic and instrumental dilatation to make rapid delivery. The same is true of delivery at full term. The labor pains are many and severe, and the accoucheur becomes weary of his task before delivery is complete. Many times he is forced to resort to manual means of various kinds to complete the delivery, and this is done with lacerations and other injuries. If he does not understand this tonic state of his patient, it is a mystery to him why the delivery should be so difficult for these are the women of the plethoric type who had never seen a day of real sickness and should have the strength to deliver themselves without difficulty. But the delivery of such patients frequently results in so much shock and injury that the plethoric state too often reverts into a state of anemia with general nervous depression. This condition may be recalled by any obstetrician of much experience. The idiosyncrasy has the major part in this condition; but the pressor agents having augmentory action through the thoracico-lumbar nerves most often have their part in augmenting the cause. The mental state may be the major cause. The toxic amines from focal infections sometimes serve as a cause. Toxic products from faulty elimination may be active causes and it is woe to the accoucheur who permits these agents to elevate the blood pressure to a state of hypertension. With uremic convulsions to appease, and a hypertonic os to dilate, two lives hang in the balance with the beam tipping toward the grave for both. These are difficult cases which the obstetrician encounters unawares and wishes that his occupation were different. When it is possible, the obstetrician should know his patients before the day of delivery and he should use the means at his disposal to prevent such difficulties. . . .

"With the hypotensive type (of patient) there are seldom any serious lacerations of the os or the perineum; but, without lacerations, these women frequently suffer in after years from prolapse of the uterus, on account of the relaxed condition of the sphincter of the vaginal outlet. While the tonic type requires special care to prevent toxemia, the hypotonic class requires special care to prevent hemorrhage. In prenatal treatment, the former requires depleting treatment to prevent toxemia; while the latter requires tonics of iron, calcium and cod liver oil."

* Words in parenthesis are mine. K.A.M.

I would like to add a postscript with reference to a condition concerning which I have had no personal experience. We all know that fibroids are frequently found in spinsters, but to explain this we usually invoke the idea of "physiological disuse" which is not very clear or convincing.

E. Kehrer is a German gynecologist (not a psychiatrist or psychoanalyst) who has contributed numerous articles maintaining that uterine fibromyomata are definitely related to disturbed psychosexuality. In his experience, women leading satisfactory sexual lives do not get fibroids and every patient with a fibroid has a history of chronic psychosexual disturbance. The disturbed psychosexuality leads to disturbances in the blood and lymph distribution of the pelvic organs and it is this which, in turn, leads to the fibroid growths. Kehrer therefore believes that fibroid development can be prevented (not cured) by psychotherapy.[6]

F. Wengraf[7] has reported four cases relevant to Kehrer's theory. In one of them a fibroma disappeared under psychotherapy; in another an ovarian cyst disappeared; in a third a small fibroma ceased to grow larger. In other words, he agrees with Kehrer's theory and goes further; he states that it is entirely possible to bring about the disappearance of a fibroma or to arrest its growth by correcting the psychoneurotic disturbances leading to chronic psychosexual maladaptation. He concedes that he has had many failures as well as some successes, but this of course does not disprove his theory.

G. R. Heyer[8] stated in 1927 that endometritis is not necessarily an inflammation but very often a hyperemia resulting from continued unrelieved excitement.*

The most convincing evidence in the gynecological field of the way in which psychological processes can influence physical structure is the phenomenon of false pregnancy. These astonishing cases remain largely unexplained, and a fruitful field for further gynecological-psychiatric cooperative research. The attention of the reader is particularly directed to the monograph by Bivin and Klinger[9] and the excellent summary with case reports, analysis of mechanisms and competent bibliography by Ruth Moulton[10]: "Some cases seem to consist of an hysterical mimicking of the external signs of pregnancy, with few endocrine changes except amenorrhea. The mechanism for this is probably a suppression of ovarian activity by the pituitary.

* This made no impression on me until I saw a patient, a married woman of 28 who, in spite of a strict upbringing, suddenly at the age of 27 had become quite promiscuous; a dozen or more sexual affairs failed in every instance to fully gratify her. She married but remained frigid and soon afterwards became ill with a condition diagnosticated by a competent gynecologist as endometritis. She was hospitalized and treated for this and recovered but her emotional state remained as before.

The amenorrhea of pregnancy is at least partly maintained by the high gonadotropic output, so that the endocrine changes in this simpler type of pseudocyesis are in the direction of those in pregnancy. The second type is that of older women with further endocrine involvement such as objective changes in the uterus and breast; here the physical process seems to be a more profound, or at least more obscure, psychosomatic one, although in the same general direction as suggested by the first type."

In this brief article I have tried to suggest that emotional factors must be considered even in those gynecological and obstetrical cases in which there is undoubted organic pathology. I began by presenting a case in which there was some evidence that emotional factors determined a fatal uterine hemorrhage; I then discussed a condition in which we are able to trace a connection between emotional factors and structural pathology in some instances, namely, pelvic muscle hypotonicity, as seen in prolapse and near prolapse, asthenic dystocia and obstetrical lacerations. Finally, I referred to theories advanced to relate fibromyomata and endometritis to emotional factors, and mentioned the condition of false pregnancy, the structural mechanics of which are understood less than the psychological dynamics.

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MENNINGER FOUNDATION ACTIVITIES

The first annual meeting of the Menninger Foundation was held in Topeka on October 6. It was attended by a quorum of members and trustees although war restrictions and complications in regard to travel made it impossible for many to come who had hoped to do so.

The meeting was devoted to the reading of reports, discussion of the aims and immediate projects of the Foundation, and the re-election of the retiring panel of trustees for a term of three years. The annual meeting of all members was followed immediately by a meeting of the Board of Trustees at which a printed annual report was approved, arrangements were made for the selection of an executive assistant to aid the secretary especially during his absence with the armed forces, policies with regard to inviting contributions to the general fund were discussed and officers for the second year elected.

The reports of research in progress made to the members have appeared, in substance, in previous issues of this Bulletin. The research projects for which application has been made or for which special assignments have been considered, if and when sufficient funds have been accumulated, include among others the following psychosomatic investigations:

a. Research in Arthritis. This painful and crippling malady is still in many respects an enigma. Many theoretical studies have postulated emotional factors in its causation, but there are no thoroughgoing research studies into the exact emotional factors.

b. Research in Peptic Ulcer. Some studies in this field have already been carried on in various centers, but the prevalence of this condition—forecast by many authorities to be on the increase during war-time stress—necessitates further studies. Approximately one-third of the Canadian soldiers invalided back to Canada in World War II were found to have peptic ulcer.

c. Research and Treatment in Menstrual Disorders. Dysmenorrhea (painful menstruation) offers a rich field of investigation into the emotional factors involved in its causation.

d. Research in Hypertension. Certain kinds of high blood pressure depend primarily on emotional disturbances, yet result finally in an irreversible, sometimes fatal physical disease. The need is great for further investigation and treatment studies which will enable medicine to institute preventive measures as well as effective treatment procedures for early cases.

In addition, for the correlation of psychiatric and medical studies, a small, well-equipped research hospital is necessary in which could be carried out intensive research studies of selected cases from the psychological, chemical, physical and psychiatric standpoints. A building site has already been ofiered; the medical staff is available. Building construction is impossible until the war is won.